KGH Master Performance Report

Q1

Fiscal 2011 - 2012
1st Quarter ended June 30, 2011
Date: September 2011

Kingston General Hospital

Outstanding care, always™

KINGSTON GENERAL HOSPITAL

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KGH Master Performance Report
Fiscal 2011 - 2012

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- OR Hours (Inpatient & Outpatient)
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Enabler 3

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Enabler 4

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Strategy milestone 1

15 patient experience advisors are integrated into KGH committees

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Integrate patient experience advisors into key KGH activities
Indicator(s)		**Status**
Number of Patient Experience Advisors on Key Planning/Decision Making Forums		Green

1. **What are the contributing factors?**

   Medical College of Georgia visit in May triggered new & varied interest in engaging Patient Experience Advisors (PEAs) in corporate activities. This has increased understanding of PFFC as well as interest and demand for PEA's, and has added to the ways in which they contribute. At the time the indicator target was set, it appears we underestimated the rate of growth in interest and capacity to support placement within groups.

2. **Are we on track to meet the milestone?**

   Yes, in fact with the 18 PEAs now in place and engaged in planning/decision making forums (15 councils & 16 short term task groups) ; in staff interviews, and in making presentations during orientations, the target of 15 has been exceeded by 3.

3. **Actions planned/underway**

   Continue recruitment of PEA's, and promoting engagement with initiatives that support the strategy. Tracking contribution of hours and nature of engagement. Open to revisiting the target. Also submitting and getting acceptance of proposals to present on this initiative at external conferences (RNAO best practice, Change Foundation, OHA). We are enhancing the capacity of PEAs to contribute to the organization through a variety of educational initiatives.

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Milestone #1

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD1 Transform the patient experience	15 Patient experience advisors are integrated into KGH committees		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	R	R	Y	Y	G	

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

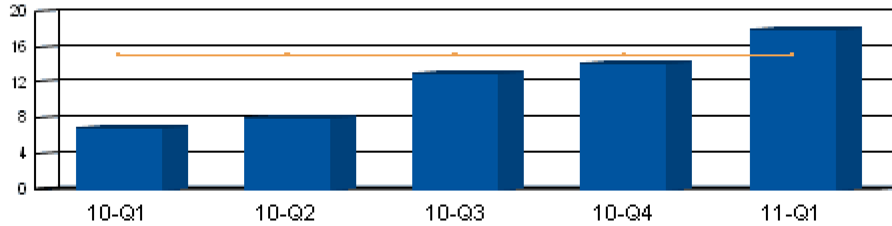
Kingston General Hospital

Milestone #1

SD1 Transform the patient experience through a relentless focus on quality, safety and service

15 Patient experience advisors are integrated into KGH committees

Indicator: Number of Patient Experience Advisors on Key Planning/Decision Making Forums



	Actual	Target
10-Q1	7	**15**
10-Q2	8	**15**
10-Q3	13	**15**
10-Q4	14	**15**
11-Q1	18	**15**

Interpretation - Patient And Business:

18 Patient Experience Advisors hold positions on councils, committees and working groups throughout the organization. This ensures that the patient voice is being heard where many decisions on patient care are being made.

Actions & Monitoring Underway to Improve Performance:

Patient and Family Centred organizations encourage the presence of two advisors on any committee. We will work at ensuring there are at least two Patient Experience Advisors where ever patient care is discussed. We are actively working at orienting advisors to the Mental Health Program Council. The SPA and OB/GYN Program Councils still need advisors. An advisory council is being established for the Regional Cancer Centre. We are working at including advisors in all hiring interviews. The Joint Planning Office is also looking at ways to include advisors in their projects. The organization needs to be intentionally including advisors as initiatives/projects are begun.

Definition: KGH is committed to ensuring the patient voice is heard at every level of the organization. To that end Patient Experience Advisors are being recruited and supported for membership on all councils, committees, task forces and working groups which have anything to do with the patient experience.

Target: QIP 11/12 Target: 15

Strategy milestone 2

Overall patient satisfaction is at or better than the provincial teaching hospital average

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Improve patient satisfaction
Indicator(s)		**Status**
Overall Acute Inpatient Satisfaction		Green
Overall Emergency Care Patient Satisfaction		Green

1. **What are the contributing factors ?**

   The latest reporting period (F11 Q3) has exceeded target. A multifactoral approach focused on patient centered care. ICPM has led the momentum at putting the patient at the center of care linking all care givers. Patient advisory committee has been key at providing ideas and areas of focus for improving the patient experience.

2. **Are we on track to meet the milestone?**

   Yes and currently exceeding the target. There has been an increase in all 8 dimensions of care. Areas for greatest improvement are continuity, and transition, involvement of family and emotional support. The quality of food remains a significant area for improvement. Very positive results continue in Emergency Room care satisfaction as well as patients positively recommending KGH to family and friends.

3. **Actions planned/underway**

   Sustainability will be the focus going forward. In addition to continuing with the current initiatives, we will focus on improving satisfaction through the Patient and Family Advisory Council, as well as improvements in patient flow and the new meal service will be key.

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Milestone #2

Strategic Direction	Goal		Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD1 Transform the patient experience through a relentless focus on quality, safety and service	Overall patient satisfaction is at or better than the provincial teaching hospital average		Overall Acute Care Patient Satisfaction (%)	G	G	G	N/A	N/A
			Overall Emergency Care Patient Satisfaction (%)	G	G	G	N/A	N/A
			Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey	R	R	R	N/A	N/A
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question "Would you recommend this Hospital to Your Friends and Family?"	R	R	Y		N/A
			Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and Family"? (QIP)	R	R	G	N/A	N/A
	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	G	G	G	N/A	N/A
			Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	Y	R	Y	N/A	N/A

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

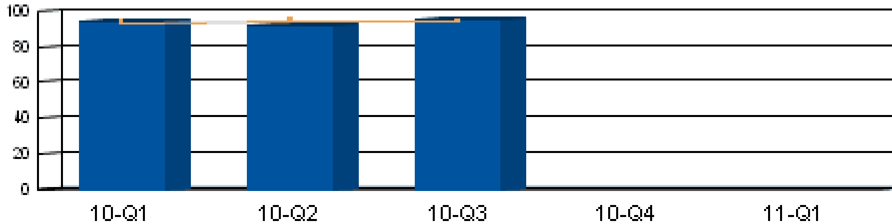
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Overall Acute Care Patient Satisfaction (%)



	Actual	Target
10-Q1	94.0	**93.4**
10-Q2	91.9	**94.6**
10-Q3	94.8	**94.0**
10-Q4		
11-Q1		

Interpretation - Patient and Business:

Overall in Quarter 3, KGH exceeded the target 94.6% by .2% this is .8% above the Ontario Teaching Hospital average and 1.8% above the Ontario average.

Although the overall Quarter 3 2011 results show an increase in satisfaction we need to strive to sustain this. We show an increase in all 8 dimensions of care. The three dimensions of care with the greatest opportunity for improvement include; continuity and transition, involvement of family and emotional support. These dimensions included specific questions related to communication and the provision of information to both patients and family members including information provided on discharge from hospital. Recent comments in the satisfaction data base show positive comments related to the receipt of the discharge summary at time of discharge.

The quality of food remains as a significant area providing an opportunity for improvement contributing to overall patient satisfaction. The results for Q3 2011 decreased to 44.9 from 49.6 the previous quarter. Our results for Q2 show KGH 13.3% below the Ontario Teaching Hospital average.

Actions & Monitoring Underway to Improve Performance:

More recently ICPM was introduced to Critical Care and plans for roll out in the ambulatory settings starts September 21, 2011. The ICPM has been rolled out to all adult medical surgical units and critical care areas and work continues with implementation and sustainability. The increase in satisfaction is influenced by ICPM and patient centred care.

Many initiatives continue that have an impact on the patient satisfaction ratings. These include the Interprofessional Collaborative Practice Model, Patient Flow and Patient and Family Focused Care, new resident orientation to KGH, Phase 2 Code of Conduct Education and more. Ongoing monitoring of the patient satisfaction results gives us trends of how the organization is meeting the needs of the patients and families we serve.

Medication reconciliation at admission continues with full implementation anticipated for 2012. The medications reconciliation at time of admission in ER, improved hand hygiene and redevelopment initiatives will support quality and safety for our patients as well as improve satisfaction.

Feedback to programs and stories through Glenna's Pick continues. Family meetings are being promoted in the clinical areas and also for resolution of concerns as this allows patient and family an opportunity to ask questions. The patient Family Advisory Council continues to contribute to improving the patient experience through presence at meetings and orientation. The presentation on patient centered care in May gave everyone who attended the impression we are on the right track to transforming the patient experience.

When the new system for meals is implemented a specific food survey will provide valuable information related to the change. Similarly the feedback on environmental cleanliness, carpet removal and redevelopment of the Main Lobby will improve satisfaction and be evident in the survey results.

Definition: The definition is the patient perception of overall care and is based on a single question (#44) on the NRC+ Picker inpatient medical/surgical survey. Pediatric, maternity and ambulatory care visits are excluded from participation. Ambulatory Care is reported elsewhere and is divided between 2 reports, Oncology reported annually and Emergency Care reported quarterly.

Target: Baseline 08/09: 93.3, Target 09/10: 93.8 or Greater, Target 10/11: Provincial Teaching Avg. or Better, Target 11/12: Provincial Teaching Avg. or Better

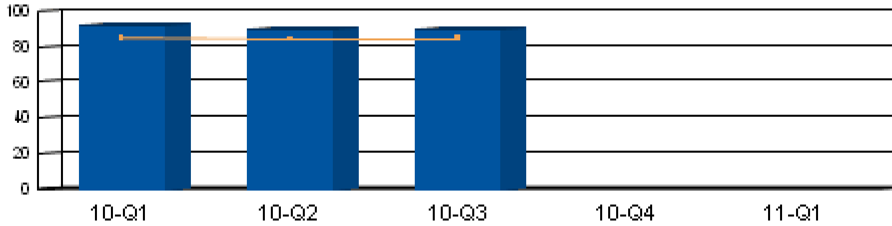
KGH Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Overall Emergency Care Patient Satisfaction (%)



	Actual	Target
10-Q1	92.2	**84.9**
10-Q2	90.1	**83.9**
10-Q3	89.6	**84.5**
10-Q4		
11-Q1		

Interpretation - Patient and Business:

Overall ED satisfaction with service remains above the Ontario Teaching Hospital average although slightly lower than the previous quarter (90.1). Patient satisfaction scores previously exceeded the target in the last 5 quarters with the last 3 quarters above 90%. Quarter 3 shows a decrease in all dimensions of care. The decrease was above the Ontario Teaching Hospital average in 2 of the dimensions: access and coordination and respect for patient preferences. The decrease in satisfaction may be attributed to increase volume and 2 critical care surges delaying admission and increasing wait times or other delays.

Actions & Monitoring Underway to Improve Performance:

The number of respondents decreased in quarter 3 to 80. Survey fatigue may be a contributing factor. Critical care surges are unpredictable and impact patient satisfaction overall. Patient Experience Advisors are part of the Emergency Program Council. Future plans include additional participation by Patients and Family members on working groups as required. We continue to share satisfaction and patient feedback reports with the clinical programs to influence change based on patient family perspective where possible. The ICPM will be introduced by March 2012.

The Medical Short Stay was established to minimize delays in the ED. The Home First Project minimizes discharge delays.

Definition: This is defined as the patient perception of overall care and is based on the single question (# 46) on the NRC+ Picker survey. The question – Overall, how would you rate the care you received in the Emergency Department? The range is based on a 5 point scale of poor to excellent.

Target: Baseline 08/09: 83.1, Target 09/10: 80.0 or Greater, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Teaching Avg. Or Better.

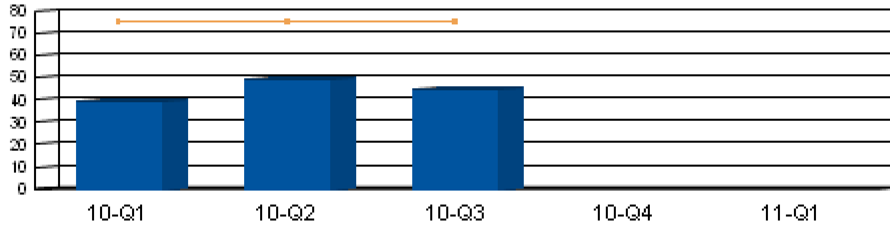
KGH Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey



	Actual	Target
10-Q1	39.4	**75**
10-Q2	49.6	**75**
10-Q3	44.9	**75**
10-Q4		
11-Q1		

Interpretation - Patient And Business:

The food service provided is currently working with an outdated delivery system. Currently the patient orders from a paper menu 24-48 hours in advance. The patient progress or condition changes and the meal ordered is not satisfying for the patient. Efforts to make make improvements include; a new delivery system that was contracted and awarded to Compass. In quarter 3 food satisfaction showed an improvement but remains well below the teaching hospital average.

The quality of food remains an opportunity for improvement contributing to overall patient satisfaction. The results for Q3 2011 decreased to 44.9 from 49.6 the previous quarter. Our results for Q2 show KGH 13.3% below the Ontario Teaching Hospital average.

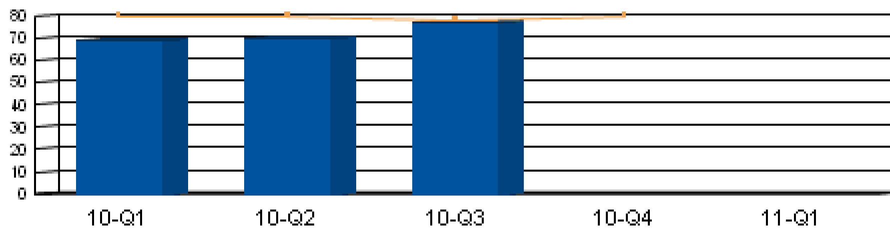
Actions & Monitoring Underway to Improve Performance:

The sampling by patients, families and staff went well in November 2010. The RFP was awarded to Compass. Pantries are currently being developed on the inpatient units to provide appropriate meal temperatures at the time of delivery as well as ordering of food will occur a couple of hours prior to delivery. Once this is completed in the late fall it is anticipated food satisfaction will increase to 75% by the end of quarter 4. Through patient feedback a change was made for patient menu choices if here longer than 2 weeks.

Definition: This is one question on the NRC+ Picker patient satisfaction report and can be compared to the Ontario hospital average and the Ontario Teaching Hospital average.

Target: QIP Target 11/12: 75%

Indicator: Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and Family?"



	Actual	Target
10-Q1	68.6	**80**
10-Q2	70	**80**
10-Q3	77	**78.2**
10-Q4		**80**
11-Q1		

Interpretation - Patient and Business:

This single question is a good indicator of a patient's satisfaction with their care and their overall experience. There was a 1.4% increase between Q1 and Q2 and a 7% increase in quarter 3. In quarter 3 all inpatient medical surgical units had implemented the Interprofessional Collaborative Practice Model.

Actions & Monitoring Underway to Improve Performance:

This single question is a good indicator of a patient's satisfaction with their care and their overall experience. There was a 1.4% increase between Q1 and Q2 and a 7% increase in quarter 3. In quarter 3 all inpatient medical surgical units had implemented the Interprofessional Collaborative Practice Model.

Definition: This is a single question from the NRC+ Picker patient satisfaction and can be compared to the Ontario Hospital average and the Ontario teaching Hospital average.

Target: 11/12 Target: Prov. Teaching Avg. or Better

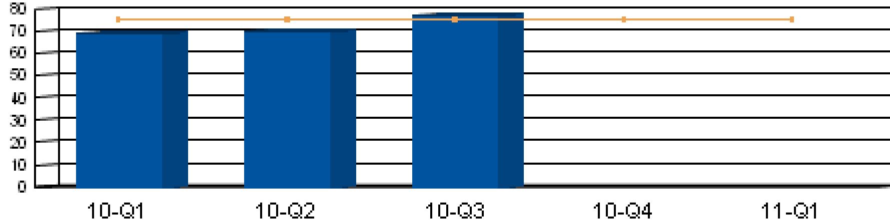
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

Overall patient satisfaction is at or better than the provincial teaching hospital average

Indicator: Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and Family"? (QIP)



	Actual	Target
10-Q1	68.6	**75**
10-Q2	70	**75**
10-Q3	77	**75**
10-Q4		**75**
11-Q1		**75**

Interpretation - Patient and Business:

This single question is a good indicator of a patient's satisfaction with their care and their overall experience. There was a 1.4% increase between Q1 and Q2 and a 7% increase in quarter 3. In quarter 3 all inpatient medical surgical units had implemented the Interprofessional Collaborative Practice Model. Patient flow activities also contributed to satisfaction overall.

Actions & Monitoring Underway to Improve Performance:

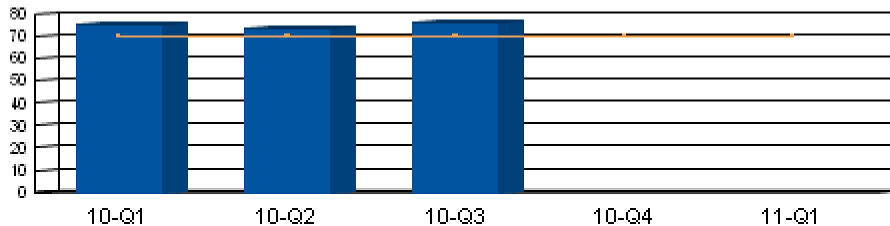
Marked increase compared to previous quarter. The plan is to continue monitoring and improve satisfaction with ICPM and patient centred care activities, patient flow and healthy work environment activities.

Definition: This is a single question from the NRC+ Picker patient satisfaction and can be compared to the Ontario Hospital average and the Ontario teaching Hospital average.

Target: QIP Target 11/12: 75%

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey



	Actual	Target
10-Q1	75.0	**70**
10-Q2	73.4	**70**
10-Q3	76.3	**70**
10-Q4		**70**
11-Q1		**70**

Interpretation - Patient and Business:

The 76.3% is above target and represents the feedback which is received through the NRC + Picker Patient Satisfaction Survey which is conducted on discharge.

Actions & Monitoring Underway to Improve Performance:

Results of survey are shared with all members of environmental services staff and opportunities for improvement are incorporated into our ongoing training plan. Regular cleaning audits are performed by managers with immediate feedback to staff

Definition: The NRC + Picker corporate survey following discharge for condition of the room which include cleanliness, temperature and lighting.

Target: SSC 11/12 Target = 70%

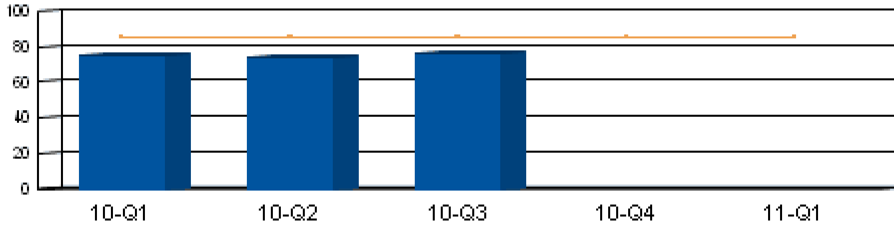
Kingston General Hospital

Milestone #2

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)



	Actual	Target
10-Q1	75	85
10-Q2	73.4	85
10-Q3	76.3	85
10-Q4		85
11-Q1		85

Interpretation - Patient and Business:

The 76.3% is below target and represents the results of the NRC + Picker patient satisfaction survey sent upon discharge. Results are shared with staff and we continue to work towards the Ontario average goal.

Actions & Monitoring Underway to Improve Performance:

Quality improvement is incorporated into our formal continuous improvement training plan. A component of our training plan are ongoing cleaning audits conducted by a third party which identifies specific details to achieve a 85% or greater.

Definition: The NRC + Picker corporate survey following discharge for condition of the room which include cleanliness, temperature and lighting.

Target: QIP Target 11/12: 85%

Strategy milestone 3

70% of our people who are surveyed rate us as "excellent" in fostering a patient safety culture

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable harm to patients is eliminated	Improve our patient safety culture

Indicator(s)	Status
Percent of Staff Surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	Red
Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	N/A

1. **What are the contributing factors?**

   The follow up survey indicator failed to show any improvement and actually a decrease in staff's perception of an organizational patient safety culture. Effective means of developing this culture is believed to be the major contributing factor.

2. **Are we on track to meet the milestone?**

   As of Q1, we are at risk of not achieving this milestone. Survey questions are divided into the following themes; senior leadership support for safety, supervisory leadership support for safety, learning culture and talking about errors/communication barriers. The initial review of results shows opportunity for improvement in all areas.

3. **Actions planned/underway**

   The survey result of only 25% satisfaction has prompted the executive group to do an in depth analysis. Action plans with accountability assigned were an opportunity exists will be created. A key recruitment for the leadership role of Director of Patient Safety and Quality is in progress. SAFE reporting e-learning module scheduled for Sept 2011 as well as patient safety week.

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Milestone #3

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD1 Transform the patient experience through a relentless focus on quality, safety and service	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture		Hospital Standardized Mortality Ratio (HSMR)	G	R	G	N/A	N/A
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data			R	N/A	N/A
			Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey				R	R

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

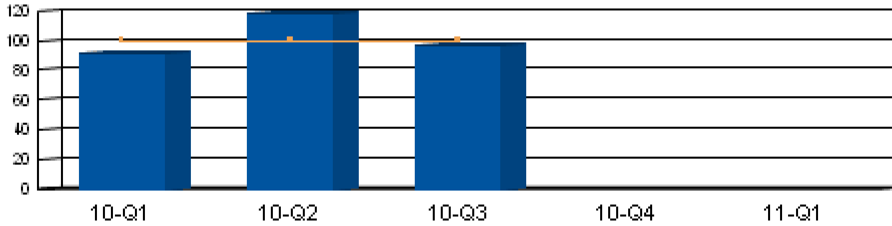
Kingston General Hospital

Milestone #3

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
10-Q1	92	**100**
10-Q2	119	**100**
10-Q3	97	**100**
10-Q4		
11-Q1		

Interpretation - Patient and Business:

The Hospital Standard Mortality Ratio (HSMR) is an important quality of care measurement tool that provides a starting point to assess mortality trends, identify opportunities for improvement and track progress. The HSMR is adjusted for factors affecting mortality, such as age, sex, and length of stay. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests that the local mortality rate is lower than the overall average. It is important to note that HSMR is not designed for comparisons between hospitals; it is intended to track a hospital's trend over time.

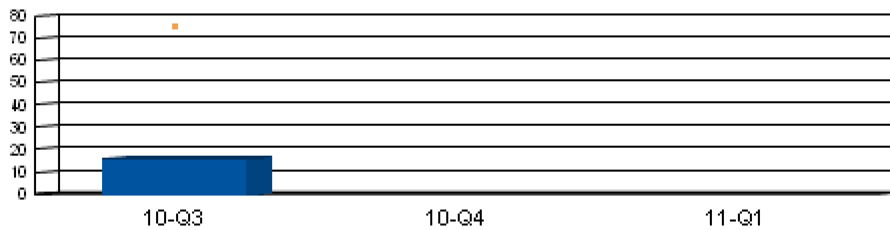
Actions & Monitoring Underway to Improve Performance:

The most recent available data from Q3 10/11 has shown a non significant HSMR. Nevertheless, quarterly reviews of moratity are conducted by the clinical departments. Concerns or trends are reported to the MAC Joint Quality and Utilization Committee.

Definition: The Hospital Standardized Mortality Ratio (HSMR) is an overall quality indicator and measurement tool used by all acute care hospitals and regions in Canada (excluding Quebec). HSMR has been used by many hospitals in several countries to help improve quality of care and enhance patient safety. The HSMR is based on diagnosis groups that account for 80% of all deaths in acute care hospitals and is adjusted for factors such as diagnosis group, age, sex, length of hospital stay, admission category, comorbidities (having multiple illnesses at once) and transfers. The Formula for HSMR is equal to the number of observed deaths divided by the number of expected deaths, multiplied by 100.

Target: Baseline 08/09: 111, Target 09/10: 100, Target 10/11: 100, Target 11/12: 106.

Indicator: Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data



	Actual	Target
10-Q3	16	**75**
10-Q4		
11-Q1		

Definition: Mortality reviews completed with quarterly review of record level HSMR data by Department Heads and reported to the Medical Advisory Committee

Target: QIP Target 11/12: 75%

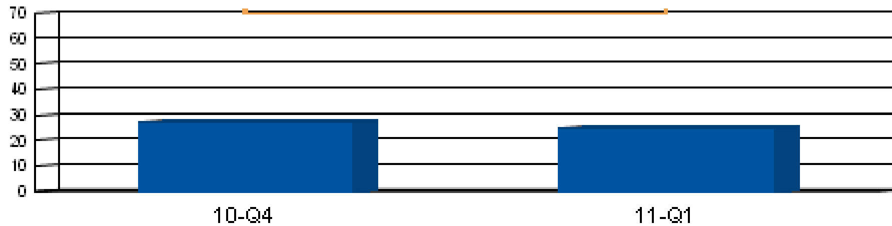
Kingston General Hospital

Milestone #3

SD1 Transform the patient experience through a relentless focus on quality, safety and service

70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture

Indicator: Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey



	Actual	Target
10-Q4	27.5	**70**
11-Q1	25.1	**70**

Interpretation - Patient and Business:

Data from May 2011 Results of the survey are based on 363 completed surveys.
The survey questions are divided into the following sections or themes; Senior Leadership support for safety, Supervisory Leadership support for safety, Learning Culture and Talking about errors/Communication Barriers.
Initial review shows opportunity for improvement in all sections of the survey.

Actions & Monitoring Underway to Improve Performance:

Further analysis of survey responses is required. The survey questions and responses are to be reviewed and action plans with accountability assigned where an opportunity for improvement exists.
Efforts and actions to support improvement include; the launch of the SAFE reporting e-learning module September 2011 which introduces safety concepts, the recruitment of the new position Director Quality & Patient Safety and work of the Patient Quality and Safety Committee. Work is currently underway in preparation for Patient Safety Week fall 2011 which will assist in creating awareness for Patient Safety at KGH.

Definition: The Patient Safety Culture Tool provides insight into staff perceptions of patient safety, allowing us to identify successes and opportunities for improvement, and monitor changes within the organization. It is based on the Modified Stanford Instrument (MSI) Patient Safety Culture Survey developed by Ginsburg et. al. (York University) The tool was recently revised by Ginsburg et. al. to ensure it reflects the most up-to-date patient safety culture research.

The Patient Safety Culture Tool includes 40 items (plus demographic items). Two items assign an overall patient safety grade of the unit and the organization. The remaining 38 items measure the following dimensions:
• Senior leadership support for safety
• Supervisory leadership support for safety
• Patient safety learning culture
• Talking about errors / communication barriers

The question on the Patient Safety Culture Survey reads;

“Please give your unit an overall grade on patient safety”
Staff responses to select from include;
- Excellent
- Very Good
- Acceptable
- Poor
- Failing

Target: Target 11/12: 70%

Strategy milestone 4

We achieve 100% hand hygiene compliance across all units and categories of staff

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable harm to patients is eliminated	Reduce hospital-acquired infections
Indicator(s)		**Status**
Hand Hygiene Compliance		Yellow

1. **What are the contributing factors?**
   A new auditing tool was introduced through the Council of Academic Hospitals of Ontario Adopting Research to Improve Care project. The hand held palm device automates data collection and analysis. At centers were it had been previously been introduced, a drop in compliance had been reported. Similarly KGH noted a 8% decrease from the previous quarter.

2. **Are we on track to meet the milestone?**
   There had been some gain in momentum in awareness and compliance over the last 2 quarters of fiscal 2011. The current Q1 has fallen to levels from fiscal 2010 Q1.

3. **Actions planned/underway**
   Hand hygiene compliance awareness remains the central focus. The HandyAudit tool data analyses by unit and provider are driving actions for improvement and follow-up. New Manager of Infection Prevention and Control and Director of Patient Safety will be key at leading organizational education and patient safety culture development. There is reinforcement of accountabilities at all levels of the organization along with posting of compliance results to increase awareness.

Kingston General Hospital

Milestone #4

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	We achieve 100% hand hygiene compliance across all units and categories of staff		Hand Hygiene Compliance	Y	Y	Y	G	Y	
			Hand Hygiene Compliance (QIP)					Y	
			Hand Hygiene Compliance (SSC)					Y	

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

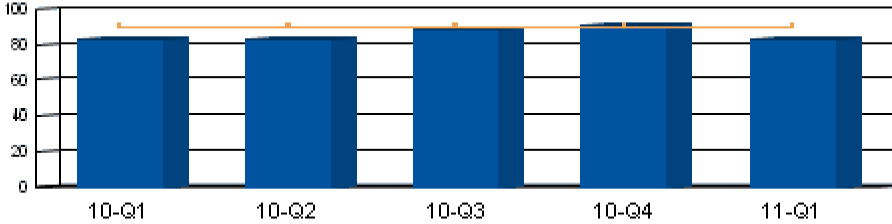
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance



	Actual	Target
10-Q1	83	**90**
10-Q2	83	**90**
10-Q3	88	**90**
10-Q4	91	**90**
11-Q1	83.3	**90**

Interpretation - Patient and Business:

Hand hygiene rates remain close to target but have slipped below target. This may be partially due to better tracking of hand hygiene using the HandyAudit tool across the hospital. Rates vary across units with many attaining HHR of 100% consistently. Efforts to continue the broad institutional awareness of the importance of hand hygiene is needed as well as targeting specific units whose rates consistently fall below 90%.

Definition: 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.

This indicator is based on the Average compliance for all four moments of Hand Hygiene (Before initial patient/patient environment contact, Before aseptic procedures, After patient/patient environment contact, After body fluid exposure risk)
- for all professions

Target: Baseline Fiscal 08/09: 44%, Target 09/10: 90%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: 90%

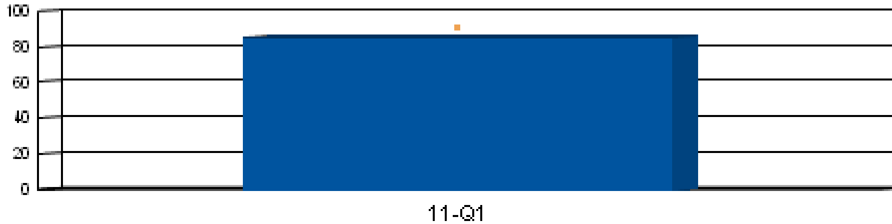
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance (QIP)



	Actual	Target
11-Q1	84.9	**90**

Interpretation - Patient And Business:

Hand hygiene rates remain close to target but have slipped below target. This may be partially due to better tracking of hand hygiene using the HandyAudit tool across the hospital. Rates vary across units with many attaining HHR of 100% consistently. Efforts to continue the broad institutional awareness of the importance of hand hygiene is needed as well as targeting specific units whose rates consistently fall below 90%.

Definition: 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.

This indicator is based on the compliance rate for hand hygiene before initial patient / Patient environment contact for all professions

Target: QIP Target 11/12: 90%

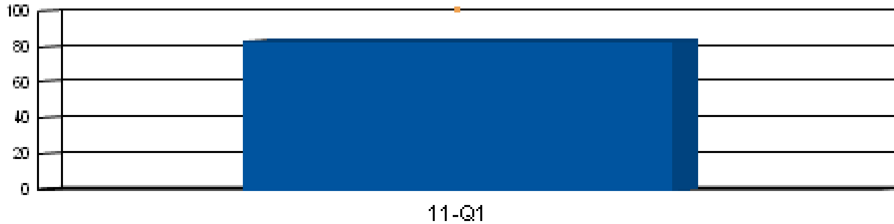
Kingston General Hospital

Milestone #4

SD1 Transform the patient experience through a relentless focus on quality, safety and service

We achieve 100% hand hygiene compliance across all units and categories of staff

Indicator: Hand Hygiene Compliance (SSC)



	Actual	Target
11-Q1	83.3	**100**

Interpretation - Patient And Business:

Hand hygiene rates remain close to target but have slipped below target. This may be partially due to better tracking of hand hygiene using the HandyAudit tool across the hospital. Rates vary across units with many attaining HHR of 100% consistently. Efforts to continue the broad institutional awareness of the importance of hand hygiene is needed as well as targeting specific units whose rates consistently fall below 90%.

Definition: 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.

This indicator is based on the Average compliance for all four moments of Hand Hygiene (Before initial patient/patient environment contact, Before aseptic procedures, After patient/patient environment contact, After body fluid exposure risk), for all professions.

Target: SSC Target 11/12: 100%

Strategy milestone 5

The number of new patients who acquire infections in our hospital is reduced by 10%

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable harm to patients is eliminated	Reduce hospital-acquired infections
Indicator(s)		**Status**
Number of New Cases of Hospital Acquired Infection		Green

1. **What are the contributing factors?**
   Reductions in the rates of CLI, VAP, VRE, MRSA set the indicator on target. A continued improvement in hand hygiene compliance is a contributing factor.

2. **Are we on track to meet the milestone?**
   Yes. The Q1 result is better than target showing 30 new patients which is 1 less than the target of 31.

3. **Actions planned/underway**
   History teaches us to focus on sustaining our reduction in infection rates. We will develop a robust antibiotic stewardship program which is critical to the management of infection control. The Manager of Infection Prevention and Control leadership has be filled . Carpet removal is in progress supporting a cleaner patient environment. A formal sepsis case review process has been developed and will be implemented in Q2. *(Please note that subsequent to Q1, there has been a C-diff outbreak)*

Milestone #5

			10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The number of new cases who acquire infections in our hospital is reduced by 10%	Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days	R	R	Y	R	R	↑
		C-difficile	R	R	R	R	R	↓
		C-difficile (QIP)	R	G	R	R	G	↑
		Central Line Bloodstream Infections	G	G	G	G	G	↓
		Environmental Audits	Y	Y	G	G	Y	↓
		MRSA (Methicillin-resistant Staphylococcus aureus)	Y	R	R	Y	Y	↑
		Number of New Cases of Hospital Acquired Infection	R	G	R	R	G	↑
		Percent of Sepsis Cases Reviewed by Department Head				N/A	N/A	
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
		Ventilator Associated Pneumonia	R	G	G	G	G	↓
		Ventilator Associated Pneumonia (QIP)	R	G	G	G	G	↓
		VRE (Vancomycin-resistant Enterococcus)	G	Y	Y	G	Y	↓

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

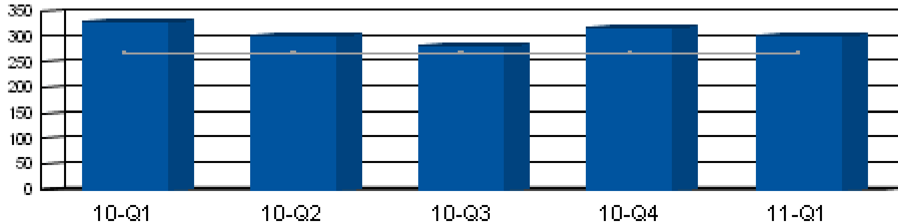
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days



	Actual	Target
10-Q1	331	**267**
10-Q2	301	**267**
10-Q3	281	**267**
10-Q4	317	**267**
11-Q1	303	**267**

Interpretation - Patient and Business:

Antimicrobial resistance is a known major public health issue, and antimicrobial stewardship, the appropriate use of antimicrobial agents, is critical to stemming the continued emergence of antimicrobial-resistant organisms.

The increasing recognition of the health burden associated with hospital-acquired infections in Canada and the increasing evidence that the use of antimicrobials in hospitals is a critical determinant of infection rates due to the most important hospital-acquired pathogens, methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile, emphasize the urgency of developing and facilitating antimicrobial stewardship programs. Literature has shown that appropriate use of antimicrobials can reduce occurrences of antibiotic resistant organisms.

Actions & Monitoring Underway to Improve Performance:

KGH's current usage of antibiotics is above target. The Infection Prevention and Control Service will take the lead in implementation of an antibiotic stewardship progarm (ABSP) working with and through the Patient Safety and Quality Committee. The MOH has also just recently announced its intentions for a provinical ABS project. Curtailing antibiotic usage is expected to have impact by reducing the incidence and frequency of nosocomial infections and outbreaks, especially C. difficile.

Definition: The Targeted Antimicrobial Use Indicator is a measure of institutional antimicrobial consumption of broad-spectrum antibacterials. Overuse of antibiotics is associated with the emergence of antimicrobial resistance and selection of some pathogens for example, Clostridium difficile. The indicator permits monitoring using a surrogate marker for institutional trends in overall antimicrobial use. Early warning of increasing patient exposure to antibiotics may become evident with monitoring. Conversely, the impact of interventions aimed at reducing overall patient exposure to antibiotics may become apparent. The total number of defined daily doses (DDD) of targeted antibiotics per 1000 patient-days using the World Health Organization Anatomical Class (WHO ATC) definition of DDD [assumed average maintenance dose per day for a drug used for its main indication in adults].The targeted antibiotics are: carbapenems (ertapenem, imipenem, meropenem, doripenem); third and fourth generation cephalosporins (cefepime, cefixime, cefotaxime, ceftazidime, ceftriaxone); extended-spectrum penicillins (piperacillin, piperacillin-tazobactam, ticarcillin-clavulanate); fluoroquinolones (ciprofloxacin, levofloxacin, moxifloxacin) and clindamycin. The numerator is the total DDDs of targeted antimicrobials, as extracted from GE Centricity Pharmacy Version 8.2 software reports detailing quarterly drug issuance to all patient care units, including Emergency. The denominator is the Quarterly Patient Days Grand Total from the Hospital's Bed Census Report.

Target: 267 DDD/1000 patient days (based upon 5% reduction from that measured during Fiscal 2011 Q3.

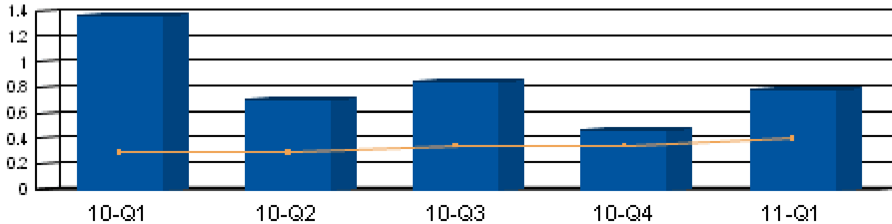
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: C-difficile



	Actual	Target
10-Q1	1.36	**0.29**
10-Q2	0.7	**0.29**
10-Q3	0.84	**0.34**
10-Q4	0.47	**0.34**
11-Q1	0.78	**0.4**

Interpretation - Patient and Business:

Please note values are monthly (Feb. - June 2011).

Definition: Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.

All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.

The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: Target 09/10: 0.26 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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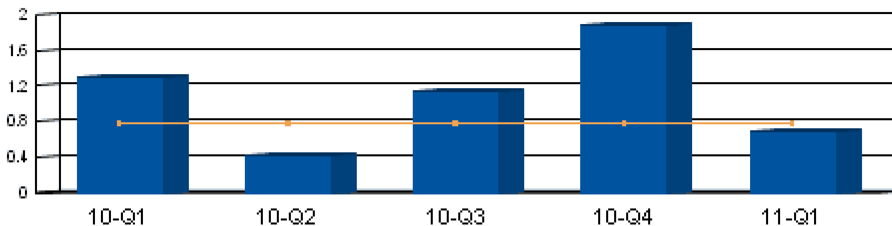
Indicator: C-difficile (QIP)



	Actual	Target
10-Q1	1.3	**0.77**
10-Q2	0.42	**0.77**
10-Q3	1.15	**0.77**
10-Q4	1.89	**0.77**
11-Q1	0.7	**0.77**

Interpretation - Patient and Business:

Acceptable rate achieved through multi-pronged approach including: environmental cleaning, aggressive isolation and reduction in antibiotic use. Continued attention to these interventions will be needed to maintain acceptable rates of CDI.

Definition: Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.

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The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

Target: QIP Goal = 0.30, QIP Target For Compensation = 0.77

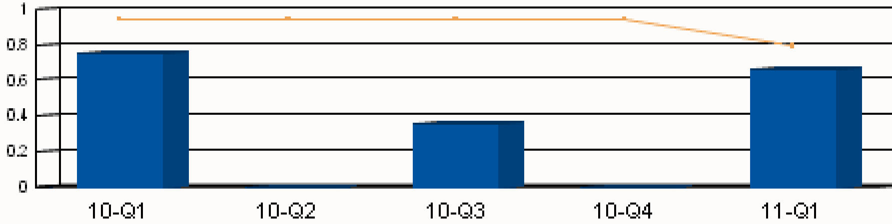
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Central Line Bloodstream Infections



	Actual	Target
10-Q1	0.75	**0.94**
10-Q2	0	**0.94**
10-Q3	0.36	**0.94**
10-Q4	0	**0.94**
11-Q1	0.66	**0.79**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Actions & Monitoring Underway to Improve Performance:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: A central line infection (CLI) occurs when a central venous catheter (or "line") placed into a patient's vein becomes infected. A CLI occurs when excessive numbers of bacteria grow on the line, which can lead to blood stream infection. Patients may require a central line when blood, fluid replacement and/or nutrition need to be given to them intravenously. Central lines also allow health care providers to directly monitor fluid status and make determinations about the cardiovascular status of a patient.
A CLI case is defined as an ICU patient who developed a blood stream infection (BSI) a minimum of 48 hours after the insertion of a central line.

The ministry will report and post on its website by hospital site the number of CLI cases that developed in the ICU in each hospital site. Where the number is zero (0) or where the cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases" and the CLI rate (per 1000 central line days)

The CLI rate is determined by the total number of newly diagnosed CLI cases in the ICU after at least 48 hours of receiving a central line, divided by the number of central line days in that month, multiplied by 1,000. Central line days are the total number of days a central line was used in ICU patients 18 years and older.

Target: Target 09/10: 1.2 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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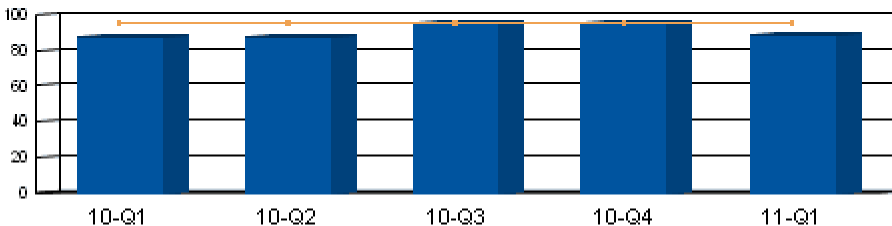
Indicator: Environmental Audits



	Actual	Target
10-Q1	87	**95**
10-Q2	87	**95**
10-Q3	95	**95**
10-Q4	95	**95**
11-Q1	88	**95**

Interpretation - Patient and Business:

The recent quarter audits have been conducted with our part-time staff resulting in the 88%. The ongoing auditing provides training for part-time staff and improvements will continue to reach our target of 95%.

Actions & Monitoring Underway to Improve Performance:

Using the audit and our formal training program improvements will achieve our desired results. The audits are used as both an evaluation of our cleaning and provide immediate feedback for improvement for our part-time and full-time staff.

Definition: The environmental audit indicator evaluates and measures the effectiveness of daily patient room cleaning. The audit identifies opportunities to focus education and training needs. The audit uses a glow germ potion and glow bar UV lamp on frequently touched surfaces in randomly selected patient rooms for an overall representation of cleaning. The percentage is determined on glow germ removed.

Target: QIP Target 11/12: 95%

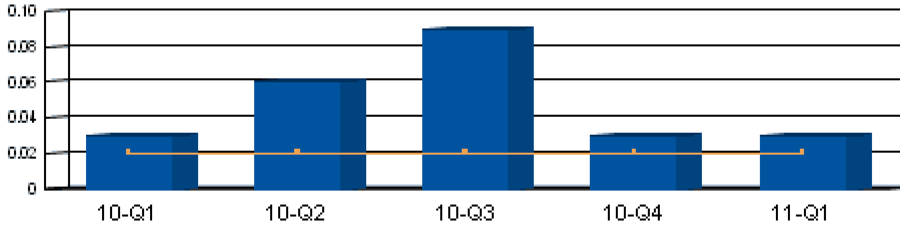
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: MRSA (Methicillin-resistant Staphylococcus aureus)



	Actual	Target
10-Q1	0.03	**0.02**
10-Q2	0.06	**0.02**
10-Q3	0.09	**0.02**
10-Q4	0.03	**0.02**
11-Q1	0.03	**0.02**

Interpretation - Patient and Business:

Rates strongly correlated with hand hygiene rates. Emphasis on maintaining high rates of hand hygiene are needed to meet acceptable target.

Definition: Staphylococcus aureus is a bacterium that periodically lives on the skin and mucous membranes of healthy people. Occasionally S. aureus can cause an infection. When S. aureus develops resistance to the beta lactam class of antibiotics, it is called Methicillin-resistant Staphylococcus aureus, or MRSA.
A case is a patient identified with laboratory confirmed bloodstream infection with MRSA. A bloodstream infection is at least one positive blood culture for MRSA. KGH will post its quarterly rate and new case count of MRSA bacteraemia acquired in its facility on its website.
At the end of each quarter, the ministry will report the previous quarter's data on its website by hospital site including the number of new hospital acquired MRSA bacteraemia cases that is zero (0) or totaling five (5) or more associated with that hospital site, or if this is fewer than 5 cases (i.e. 1 to 4 cases), text reading "< 5 cases", and the hospital acquired MRSA bacteraemia rate.

The total number of new cases of MRSA bacteraemia acquired in the hospital in a quarter is divided by the total number of patient days for that quarter. Patient days are the number of days spent in a hospital for all patients. The results are multiplied by 1000. This represents the rate of hospital acquired associated MRSA bacteraemia associated with the reporting facility per 1000 patient days for that quarter.

Target: Target 09/10: 0.02 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

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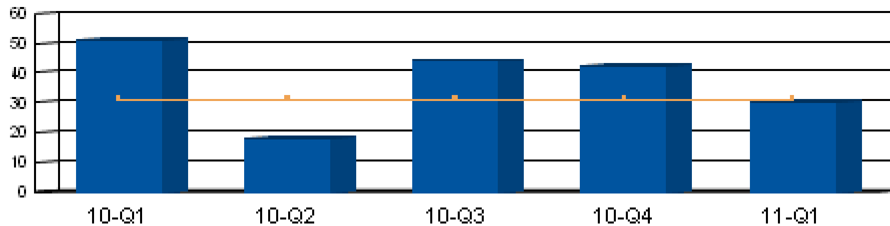
Indicator: Number of New Cases of Hospital Acquired Infection



	Actual	Target
10-Q1	51	**31**
10-Q2	18	**31**
10-Q3	44	**31**
10-Q4	42	**31**
11-Q1	30	**31**

Interpretation - Patient and Business:

Target has been achieved principally due to reductions in rates of CLBI, VAP, CDI and MRSA infections. High levels of hand hygiene have also helped to reduce transmission of HAI across the institution.

Definition: The total number of new cases of hospital-acquired infection is a performance indicator that aggregates new cases of MRSA bacteremia, CDI, and VRE bacteremia into an overall performance measure. This case count excludes colonizations. New cases are tracked on a monthly basis for each category then added and averaged for each fiscal quarter.

Target: Target 11/12: 31

Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Percent of Sepsis Cases Reviewed by Department Head

	Actual	Target
10-Q4	0	
11-Q1	0	

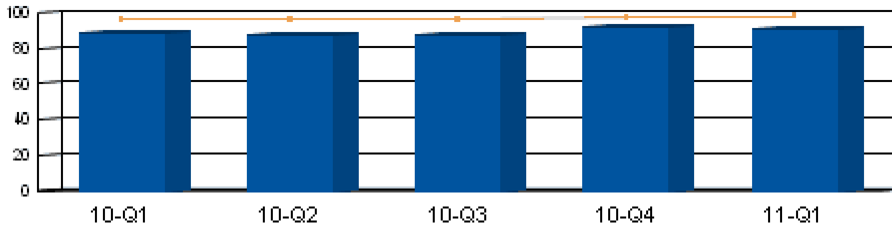
Interpretation - Patient and Business:

not yet being reported.   Expectation is initiation in Q2

Definition: Quarterly review of all sepsis cases by Department heads and reported to the Medical Advisory Committee

Target: QIP Target 11/12: 75%

Indicator: Surgical Site Infection (SSI) Prevention



	Actual	Target
10-Q1	88	**96**
10-Q2	87	**96**
10-Q3	87	**96**
10-Q4	92	**97**
11-Q1	91	**98**

Interpretation - Patient and Business:

Patient perspective: The rates of appropriate timing of prophylactic antibiotic administration for patients undergoing orthopedic procedures remain above 90% but still not at target. Rates of SSI post arthroplasty remain at low levels,

Business perspective: Identification of remaining barriers to timely antibiotic administration are are being examined by the Surgical Infection Control working group including the potential for larger doses of prophylactic antibiotics   to improve the window for timely administration by examining the kinetics of drug administration in this setting.

Definition: Prevention of surgical site infections (SSI) is multi-faceted. One of the interventions used to reduce the incidence of SSI is the use of pre-operative antibiotics typically administered to patients 0 to 60 minutes (for usual antibiotics) or 0 to 120 minutes (for an antibiotic known as Vancomycin) before they undergo surgery. This SSI prevention indicator will report the percentage of time the health care team gave patients antibiotics within the appropriate time period before the surgery. This will be measured only in patients who are 18 years or older who are about to undergo primary hip or knee joint replacement surgery, including total, partial or hemi-arthoplasty.
Hospitals will post the percentage of hip/knee joint replacement surgical patients who received antibiotics within the appropriate time period before the surgery on their website every three months (quarterly), and 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.

Target: Target 09/10: 91.95%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

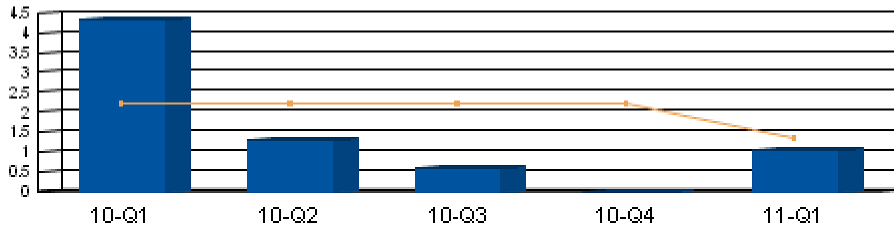
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: Ventilator Associated Pneumonia



	Actual	Target
10-Q1	4.34	**2.2**
10-Q2	1.3	**2.2**
10-Q3	0.6	**2.2**
10-Q4	0.0	**2.2**
11-Q1	1.06	**1.33**

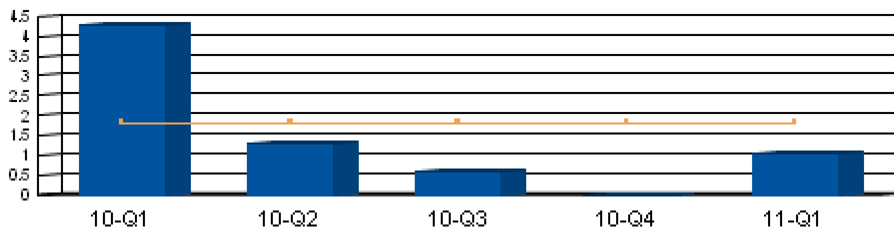
Interpretation - Patient and Business:

Consistently below target for 4 quarters with recent rise. Multi-pronged approach by ICU staff and IPAC continues to show success.

Definition: Ventilator associated pneumonia (VAP) can occur in patients, specifically those in Intensive Care Units (ICU) who need assistance breathing with a mechanical ventilator for at least 48 hours. VAP case is defined as ICU patients 18 years and older who are on ventilators (occasionally or continuously) where Pneumonia appears at least 48 hours after the patient was placed on a ventilator.
Patients are at risk of acquiring VAP if they have been on a ventilator for more than 5 days, have been recently hospitalized, had prior use of antibiotics (within the last 90 days), had dialysis treatment in a clinic or resided in a nursing home.
The ministry will publicly report and post on its website by hospital site the number of VAP cases. Where the number is zero (0) or cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases", and the VAP rate (per 1000 ventilator days).

Target: Target 09/10: 3.01 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

Indicator: Ventilator Associated Pneumonia (QIP)



	Actual	Target
10-Q1	4.3	**1.82**
10-Q2	1.3	**1.82**
10-Q3	0.6	**1.82**
10-Q4	0.0	**1.82**
11-Q1	1.06	**1.82**

Interpretation - Patient and Business:

Consistently below target for 4 quarters with recent rise. Multi-pronged approach by ICU staff and IPAC continues to show success.

Definition: Ventilator associated pneumonia (VAP) can occur in patients, specifically those in Intensive Care Units (ICU) who need assistance breathing with a mechanical ventilator for at least 48 hours. VAP case is defined as ICU patients 18 years and older who are on ventilators (occasionally or continuously) where Pneumonia appears at least 48 hours after the patient was placed on a ventilator.
Patients are at risk of acquiring VAP if they have been on a ventilator for more than 5 days, have been recently hospitalized, had prior use of antibiotics (within the last 90 days), had dialysis treatment in a clinic or resided in a nursing home.
The ministry will publicly report and post on its website by hospital site the number of VAP cases. Where the number is zero (0) or cases total five (5) or more associated with that hospital site, the number will be posted. If the cases are fewer than 5 (i.e., 1 to 4 cases), it will state "<5 cases", and the VAP rate (per 1000 ventilator days).

Target: QIP Goal = 1.82, QIP Target for Compensation = 1.82

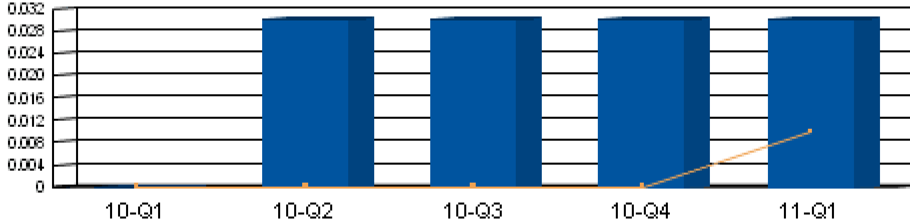
Kingston General Hospital

Milestone #5

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The number of new cases who acquire infections in our hospital is reduced by 10%

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
10-Q1	0.00	0.00
10-Q2	0.03	0.00
10-Q3	0.03	0.00
10-Q4	0.03	0.00
11-Q1	0.03	0.01

Interpretation - Patient and Business:

Patient perspective: Very low rates of true infection and no attributable mortality. Main impact is on need to isolate patients who are colonized. No appreciable change in colonizaton rates for over 2 years suggests that VRE colonization is endemic in the community rather than solely the hospital.

Definition: Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic Vancomycin. If a person has an infection caused by VRE, such as a blood infection, it may be more difficult to treat due to the availability of antibiotics active against VRE.

KGH will post its quarterly rate and new case count of VRE bacteremia.
At the end of each quarter, the ministry will report the previous quarter's data on its website by hospital site including the number of new hospital acquired VRE bacteremia cases that is zero (0) or totaling five (5) or more associated with that hospital site, or if this is fewer than 5 cases (i.e. 1 to 4 cases), text reading "< 5 cases", and the hospital acquired VRE bacteremia rate.

The total number of new cases of VRE bacteremia acquired in the hospital in a quarter is divided by the total number of patient days for that quarter. Patient days are the number of days spent in a hospital for all patients. The results are multiplied by 1000. This represents the rate of hospital acquired VRE bacteraemia associated with the reporting facility per 1000 patient days for that quarter.

Target: Target 09/10: 0.0 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better

Strategy milestone 6

100% of our clinical services discharge patients at their expected length of stay

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Actively manage patient flow

Indicator(s)	Status
Overall - Acute Average Length of Stay vs ELOS (Variance)	Green
Percent ALC Days	Red
Percent of Clinical Services Meeting ELOS Target	Red

1. **What are the contributing factors?**

   Although we have made some gains in LOS with many services, there continues to be a gridlock in patient flow. Complex patients, movement of mental health in patient care to KGH, critical care construction, carpet removal, reduction in bed numbers to meet the PIP and ALC volumes impact patient flow.

2. **Are we on track to meet the milestone?**

   As of Q1, we are at risk of not achieving this milestone. Overall, ELOS is on target with opportunities for improvement in Gastroenterology, Neurology, Radiation Oncology, General Surgery, Neurosurgery, Orthopedics, Plastic Surgery and Obstetrics and Gynecology. Readmission rates are better than target and percent ALC days continue to decrease.

3. **Actions planned/underway**

   LOS data has been presented and is available to all services and programs. Patient Flow Task Force is a key forum for planning actions to improve and address all patient flow indicators. Formal discussions have increased awareness of issues surrounding repatriation and patient transfer.

Kingston General Hospital

Milestone #6

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	G	G	G	R	↑
			Overall - Acute Average Length of Stay Days (Based on HSAA)	R	R	Y	Y	Y	↑
			Overall - Acute Average Length of Stay vs ELOS (Variance)	Y	G	G	G	G	↑
			Percent ALC Days	R	R	R	R	R	↑
			Percent of Clinical Services Meeting ELOS Target	R	R	R	R	R	↑
			Readmission rate Within 30 Days for Selected CMG's	R	G	N/A	N/A	N/A	↑

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

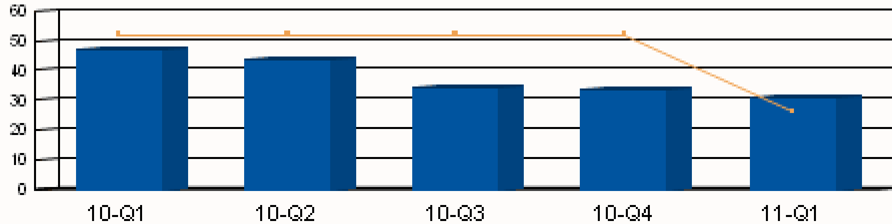
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Average # ALC Patients per Day



	Actual	Target
10-Q1	47	**52**
10-Q2	44	**52**
10-Q3	35	**52**
10-Q4	34	**52**
11-Q1	31	**26**

Interpretation - Patient and Business:

The target has been reduced to reflect closure of Connell 4 and to drive further improvements in preventing patients requiring designation as ALC and promoting earliest patient flow to the appropriate ALC destination. The first quarter is above the new target but is trending positively on month by month basis to the new target.

Actions & Monitoring Underway to Improve Performance:

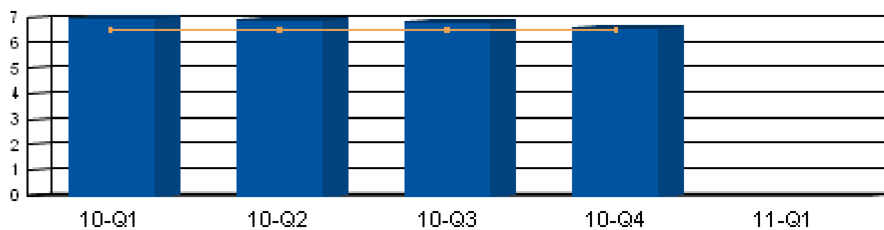
There has been reorientation within the clinical programs about expectations with the Home First program (shared initiative wtih CCAC) and also with new residents in late June. Currently 100% of eligible patients are assessed by CCAC prior to any designation of ALC. ALC rates and conversion rates are reviewed monthly at the Patient Flow Task Force with consideration of opportunities for improvement.

Task Force created in partnership with Providence Care to address issues of delay with assessment/designation of ALC in complex continuing care and rehab categories, including aspects of timing and frequency of assessments and decision meetings, transfer of information, awareness and education about resources. Approximately 25-30% of ALC patients are destined for transfer to PC and therefore improvements are expected to have impact on flow and bed access. Changes over the first quarter are showing preliminary result of decrease in the number of patients at KGH awaiting placement at PC.

Definition: When a patient occupies a bed in a hospital 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.

Target: Baseline 08/09: 60 patients, Target 09/10: 57 patients, Target 10/11: 52 patients, Target 11/12: 26 patients.

Indicator: Overall - Acute Average Length of Stay Days (Based on HSAA)



	Actual	Target
10-Q1	7	**6.5**
10-Q2	6.9	**6.5**
10-Q3	6.8	**6.5**
10-Q4	6.6	**6.5**
11-Q1		

Interpretation - Patient and Business:

The length of stay has decreased slightly but still exceeds the target, which from a patient care perspective can translate to patient and family inconvenience with imprecise discharge planning; delayed admissions of patients from the ER or through Same Day surgery; surgical cancellations, and from a corporate perspective means inefficient use of resources and potential loss of revenue or protected funding. There are specific populations where access to community based follow-up resources is currently limited (neurosurgery, vascular).

Actions & Monitoring Underway to Improve Performance:

AALOS is focus of work within program, in the Patient Flow Task Force and at MAC. All programs are tasked with achieving the target of ELOS for their patient populations (ELOS is what would be expected length of stay for the type of patients at KGH).

Definition: This indicator is a measure of how long inpatients stay in hospital. By measuring the "acute" length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed form the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay a crude measure of efficiency as it relates the use of inpatient beds.

Target: Baseline 08/09: 6.8 days, Target 09/10: 6.5 days, Target 10/11: 6.5 days, Target 11/12: 6.5 days.

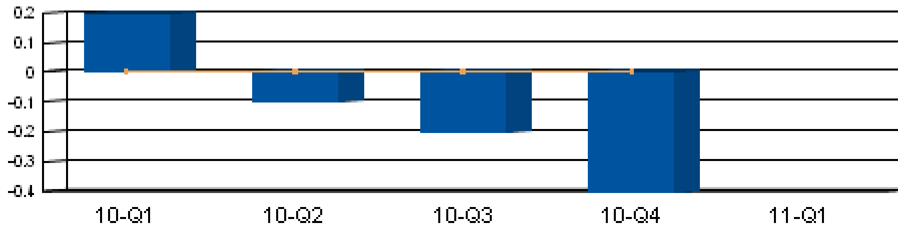
KGH Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Overall - Acute Average Length of Stay vs. ELOS (Variance)



	Actual	Target
10-Q1	0.2	0.0
10-Q2	-0.1	0.0
10-Q3	-0.2	0.0
10-Q4	-0.4	0.0
11-Q1		

Interpretation - Patient and Business:

Because this indicator is calculated using coded and abstracted medical record data, Q4 results are the latest complete fiscal quarter. A positive trend in overall performance continues. The -0.4 variance for Q4 (fiscal 10/11) indicates that overall our actual length of stay is below or better than our expected length of by 0.4 of a day. However, it is important to note that this is calculated on an overall basis. There remains opportunity to achieve expected length of stay on a service by service basis.

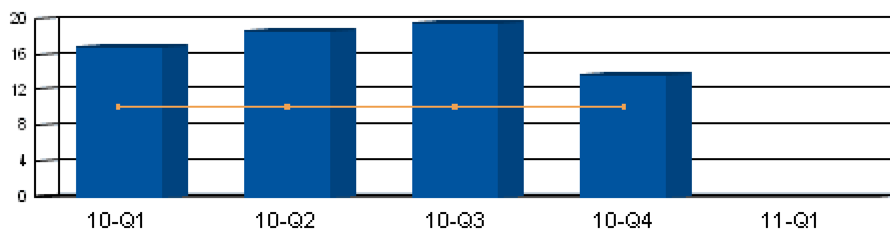
Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments on explaining these data and exploring opportunities for improvement. These data are also shared with all Program leadership for the purpose of exploring opportunities to improve length of stay.

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the "acute" length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed from the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across acute care hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay is a crude measure of efficiency as it relates the use of inpatient beds.
The expected length of stay (ELOS) is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Typical cases exclude deaths, transfers, voluntary sign-outs, and cases where the actual length of stay is greater than the ""trim point"" established by CIHI. For this measure, a positive variance indicates actual days stay was longer than expected while a negative value suggests the average actual stay was shorter than expected.

Target: 11/12 Target: 0

Indicator: Percent ALC Days



	Actual	Target
10-Q1	16.7	**10**
10-Q2	18.6	**10**
10-Q3	19.4	**10**
10-Q4	13.6	**10**
11-Q1		

Definition: When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies. The percent of ALC days (total ALC days/total inpatient days) is calculated to better understand the proportion of ALC days for a given period of time.

Target: 11/12 Target: 10%

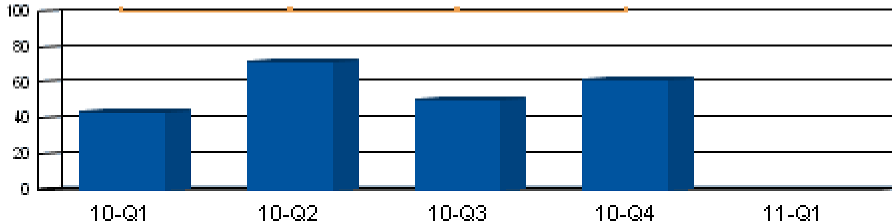
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Percent of Clinical Services Meeting ELOS Target



	Actual	Target
10-Q1	44	**100**
10-Q2	72	**100**
10-Q3	50	**100**
10-Q4	61	**100**
11-Q1		

Interpretation - Patient and Business:

Because this indicator is calculated using coded and abstracted medical record data, Q4 results are the latest complete fiscal quarter. A positive trend over the two most recent reported fiscal quarters is emerging despite performance not yet achieving target. The 61 percent of services achieving their expected length of stay for Q4 (fiscal 10/11) translates to 11 of 18 services achieving expected length of stay or better. Therefore, there remains opportunity in 7 clinical services to achieve their expected length of stay.

Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments on explaining these data and exploring opportunities for improvement. These data are also shared with all Program leadership for the purpose of exploring opportunities to improve length of stay.

Definition: This indicator is a measure of how long inpatients stay in-hospital. By measuring the "acute" length of stay, all alternate level of Care (ALC) days and any days of stay assigned to newborns are removed from the calculation. This is in keeping with MOH methodology and in support of comparing and benchmarking length of stay performance across acute care hospitals. The length of stay is calculated by subtracting the day of admission from the day of discharge from hospital. For example if a patient is admitted on a Monday and discharged on a Friday, the length of stay would be 4 days. Length of stay is a crude measure of efficiency as it relates the use of inpatient beds.

The expected length of stay (ELOS) is calculated on typical patients taking into account the reason for hospitalization, age, comorbidity, and complications. Typical cases exclude deaths, transfers, voluntary sign-outs, and cases where the actual length of stay is greater than the ""trim point"" established by CIHI. For this measure, average acute length of stay is compared to ELOS at the clinical service level (e.g. cardiology, general surgery etc.). The services with a negative variance are tallied and divided by the total number of services expressed as a percent.

Target: QIP Target 11/12: 100%

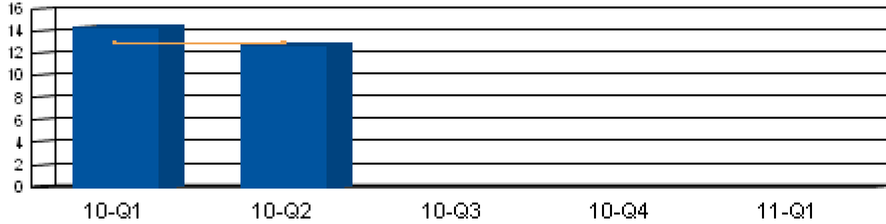
Kingston General Hospital

Milestone #6

SD1 Transform the patient experience through a relentless focus on quality, safety and service

100% of our clinical services discharge patients at their expected LOS

Indicator: Readmission rate within 30 Days for Selected CMG's



	Actual	Target
10-Q1	14.4	**12.9**
10-Q2	12.8	**12.9**
10-Q3		
10-Q4		
11-Q1		

Interpretation - Patient and Business:

30 day readmission rates in part reflect that patients received appropriate, timely care from physicians, nurses and other healthcare providers. Another factor that may contribute to lower 30-day readmission rates is well prepared instructions for discharge from the hospital. Examples include instructions on proper medication use, diet, wound care management and follow up instructions. Availability and access to CCAC/home care will play an additional role. This indicator represents the readmission rate for selected CMGs to ANY facility within the SE LHIN. A low rate of readmission would therefore be reflective of quality of care by the discharging institution and care provided in the community.

Actions & Monitoring Underway to Improve Performance:

The data is supplied to KGH from the MOH and generally will be 2 quarters behind. The current rate is below the target. An in-depth analysis of each CMG group will be reviewed by MAC Joint Quality and Utilization Committee and the Patient Safety and Quality Committee.

Definition: This indicator is calculated by the MOH and supplied to KGH via the Ministry LHIN Performance agreement (MLPA – a performance agreement that focuses on system performance and financial accountabilities. This indicator is best described as the number of patients readmitted to any facility for non-elective inpatient care, compared to the number of expected non-elective readmissions using data from all Ontario acute hospitals. The number of patients readmitted to any facility for non-elective inpatient care is defined as the observed number of patients, discharged with specific CMG's within calendar year, readmitted to any facility for any non-elective patient care within the specified number days of discharge for index admission.

Target: QIP Goal 11/12= 12.9%

Strategy milestone 7

The Emergency Department wait time for admitted patients is less than 8 hours for 100% of patients

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Reduce wait times
Indicator(s)		**Status**
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs		Red

1. **What are the contributing factors?**

   Overall, ED volumes are approximately 10% above target . ED admitted patient volumes are 12% above target and high acuity non-admitted patients are approximately 17% above target. Overcapacity on inpatient units, bed assignment processes above target ALC numbers, isolations, and staffing are impacting our ability to meet the target.

2 **Are we on track to meet the milestone?**

   As of Q1, we are at risk of not achieving this milestone. Significant effort will be required to meet the milestone and associated Pay for Performance measures. For the first time in the last five fiscal quarters 90th percentile ED wait times for admitted patients (29 hrs) is better than target (31 hrs).

3. **Actions planned/underway?**

   Increase frequency of Patient Flow Task Force meetings to every two weeks to address issues such as LOS; use of predicted discharge; patient to service alignment; consistency with patient criteria based decision making; evaluate bed allocation; accountability framework; introduce Code Gridlock; Continue work with CCAC on Home First and with Providence Care on assessment/decision/transfer processes which has resulted in a 20% decrease in pending transfers. Plan to extend same design to mental health patient population, regional hospitals and Long Term Care Hospitals as well as promoting repatriation and patriation to regional hospitals .

KGH Kingston General Hospital

Milestone #7

			10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The ED wait time for admitted patients is less than 8 hrs for 100% of patients	90th Percentile ED Wait Time (All Admitted Patients)	R	Y	R	R	G	↑
		Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)	R	R	R	R	R	↓
		Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↑
		Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	R	Y	Y	R	G	↑
		Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	Y	Y	R	R	↓
		Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	R	Y	Y	Y	G	↑
		Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R	↑

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

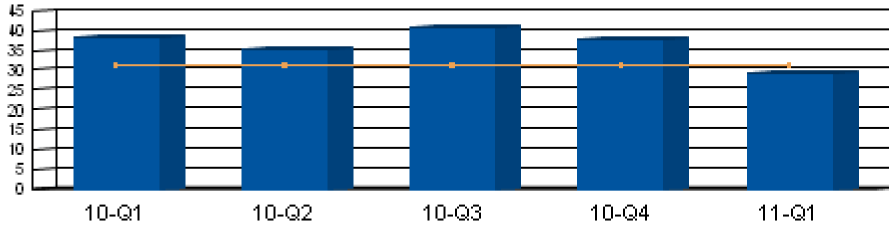
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: 90th Percentile ED Wait Time (All Admitted Patients)



	Actual	Target
10-Q1	38.4	**31**
10-Q2	35.2	**31**
10-Q3	40.9	**31**
10-Q4	37.6	**31**
11-Q1	29.2	**31**

Interpretation - Patient and Business:

We are meeting the target of 9/10 patients spending less than 31 hours in the Emergency Department waiting for an inpatient bed. At the end of Q1, 10% of admitted patients waited longer than 29.2 hours for an inpatient bed. This is an improvement of 7.8 hours over last quarter and 9.2 hours over same quarter last fiscal.

Actions & Monitoring Underway to Improve Performance:

LOS in the ED will be continuously monitored in real time with EDIS. One of the other indicators is to move all admitted patients to inpatients within 8 hours of registration in ED so we continue to aim for this target through various initiatives.
Consultant times are also being monitored and intervention when required.

Definition: 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: QIP Target 11/12: 31 Hours

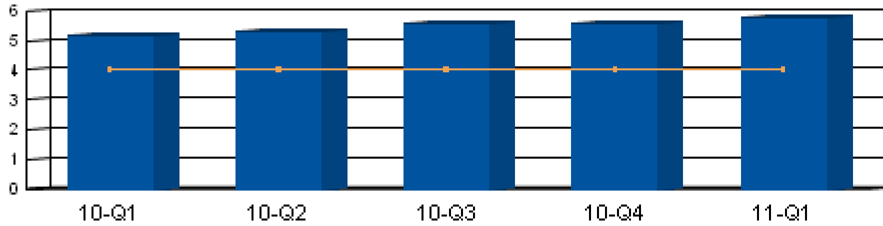
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)



	Actual	Target
10-Q1	5.2	**4**
10-Q2	5.3	**4**
10-Q3	5.6	**4**
10-Q4	5.6	**4**
11-Q1	5.8	**4**

Interpretation - Patient and Business:

Patient Perspective: Based on the Q1 results, KGH is failing to meet the ED 90th percentile wait time target of 4hrs. At 5.8 hours, we are sustaining gains made over the previous fiscal year but have not met the target. Ten percent of patients in this category had a total length of stay longer than 5.8 hours. Physician Initial Assessment (PIA) time is under 2.4 hours. This PIA time along with the timely movement of patients from the waiting room has significantly reduced the number of patients who have left without being seen (LWBS).

Business Perspective: Although there is no financial penalty for not meeting this wait time target there is incentive pay through the provincial Pay for Results program for each patient in this low acuity non-admitted category seen and treated within the 4 hours target.

Actions & Monitoring Underway to Improve Performance:

Volumes have increased in the higher acuity category which means less acute patients may be waiting longer to be seen due to physician availability. As of September, additional physician hours will help to reduce the PIA time even further. Since PIA is already under the target of 2.42 hours, delays can be attributed to turn-around times for test results, treatment and delays in reassessment.

EDIS is helping to monitor turn-around times and alert physicians when results are ready for review.

Definition: This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and being discharged from the ED. 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 discharged from the ED. 9 out of 10 patients whose conditions are minor or uncomplicated and require less time for treatment, diagnosis or observation will spend no more than 4 hours within the ER from the time they arrive and register to the time their visit is complete and they are discharged. CTAS (Canadian Triage & Acuity Scale) 4 or 5 are used to describe ‘Minor or Uncomplicated’.

Target: Baseline 08/09: 7.0hrs, Target 09/10: 4hrs, Target 10/11: 4hrs, Target 11/12: 4hrs.

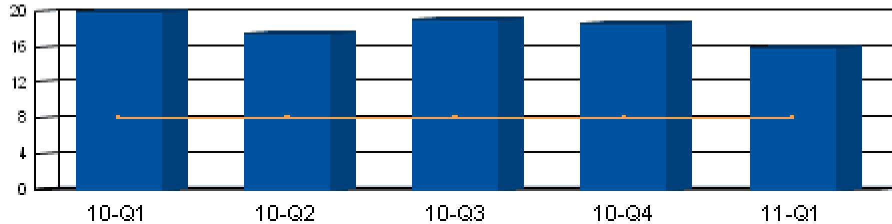
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)



	Actual	Target
10-Q1	19.9	**8**
10-Q2	17.5	**8**
10-Q3	19.1	**8**
10-Q4	18.7	**8**
11-Q1	15.8	**8**

Interpretation - Patient and Business:

Patient Perspective: Based on the Q1 results, KGH is failing to meet the ED 90th percentile LOS target of 8 hrs for admitted patients with complex conditions. The majority of admitted patients breeching the 8 hour target are medicine patients waiting for an available inpatient bed on a medicine unit (given pure volumes of admitted patients to the medicine program). There are quality of care and patient satisfaction concerns when patients are not admitted to an inpatient bed once the decision to admit has been made. LOS in ED has reached over 100 hours. Nine of 10 patients are admitted to an inpatient bed within 15.8 hours and one in ten admitted patients spent greater than 29.2 hours on a stretcher in ED during Q1.
Q1 of this fiscal has been our best performance to date.
Business Perspective: Inefficiencies are created that have a negative financial impact on the hospital (e.g. carrying for admitted patients in the Emergency Department during the most expensive part of their stay).
Year4 Pay for Results program has built in incentives to move patients within the 8 hour time frame which means additional funding for each patient moved to an inpatient bed within the 8 hour time frame.

Actions & Monitoring Underway to Improve Performance:

Initiatives throughout the hospital and within each program are in progress to improve performance. e.g. medicine short stay unit, surgical short stay unit (opened September), offload nurse, EDIS, improved process for lab result notification, reduce bed empty time, medicine bed manager, and a change in process for placing patients with responsibility shifting to the Bed Allocators.

There is bed capacity within the hospital to move all admitted patients out of ED. The issue is with the location of the bed and the program the bed is in.

A drop in weekend discharges contributes to a bottleneck in ED on Monday mornings and then the early part of the week is spent "catching up".

Often, patients do not get admitted until they have been in ED longer than 8 hours meaning the breach occurs before the time of conversion from outpatient to inpatient. This occurs often times when consults are not done in a timely fashion or there is a delay in decision to admit.

Definition: 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 a hospital bed. 9 out of 10 patients with complex conditions that may require more time for treatment, diagnosis or admission to a hospital bed will spend no more then eight hours within the ER from the time they arrive and register to the time they leave the ER. CTAS (Canadian Triage & Acuity Scale) 1, 2 or 3 are used to describe ‘Complex’.

Target: Baseline 08/09: 22.4hrs, Target 09/10: 8hrs, Target 10/11: 8hrs, Target 11/12: 8hrs.

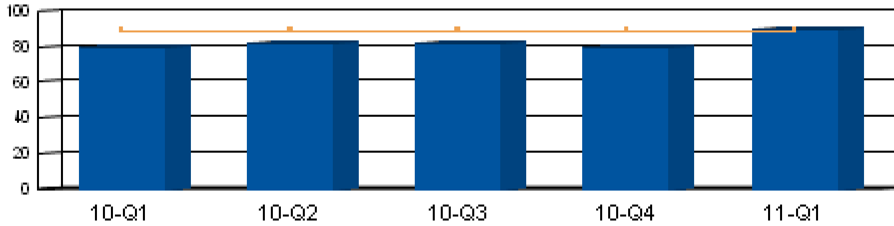
KGH Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)



	Actual	Target
10-Q1	79	**89**
10-Q2	82	**89**
10-Q3	82	**89**
10-Q4	80	**89**
11-Q1	90	**89**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q1 results the ED has improved the ED wait time achieving the 90% target for the non admitted CTAS 1, 2 and 3 patients. Fewer non-admitted high acuity patients are waiting in the ED longer than the 8 and 6 hour targets compared to same time last year. An improvement of 10 percentage points has been achieved over last quarter.

Business Perspective: Year 4 Pay for Results funding has been received which will enable us to implement initiatives to help with patient flow, some money is held back as incentive pay for performance. There is incentive pay for each patient treated within the target time frame.

Note: The description of this indicator states CTAS 1 and 2 have an 8 hour target, while CTAS 3 has a 6 hour target. Under Pay for Results, this indicator has been changed to 7 hours for CTAS 1 - 3 and 8.7 hours at the 90th percentile.

Actions & Monitoring Underway to Improve Performance:

Initiatives are planned or in progress to meet the targets e.g. improve lab result notification, improvement of the Urgent Track fto include ambulatory CTAS 3 patients, realignment of medical coverage in the ED to patient arrival times. Plans for a triage transition nurse will help to ensure triage and quick and patients in this category will be brought to a stretcher quickly for a more rapid assessment and treatment.

A dedicated off-load nurse helps to ensure patients arriving by ambulance do not wait to be "off-loaded" and are assessed by this nurse upon arrival. Average off-load time this quarter is 9 minutes.

In Q3 of last fiscal a virtual Clinical Decision Unit (CDU) was implemented. This 6 bed virtual allows us to "admit" patients within the ED who we know in advance will breach the 8 hour target but do not need to be admitted. There are predetermined criteria as to which patients can be admitted to the CDU. The CDU LOS at the 90th percentile is 18 hours and the admission rate is 25% (allowed up to 30%).

Definition: There are three Emergency Department (ED) wait time metrics that are directly tied to the Provincial ED Pay for Results initiative which is focused on reducing ED wait times. Each metric is designed to focus on a particular cohort of patients that present to the ED and each one has been assigned a target. The MOH provided selected hospital with funding to support initiatives aimed at improving patient flow. This measure represents the percentage of non-admitted high acuity patients treated within a wait time target of less than 8hrs (CTAS 1-2) and less than6hrs (CTAS 3). The 8 and 6 hour wait time targets are measured from the time of registration in ED to the time the patient leaves the ED.

(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level 1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 77%, Target 09/10: 87%, Target 10/11: 89%, Target 11/12: 87%

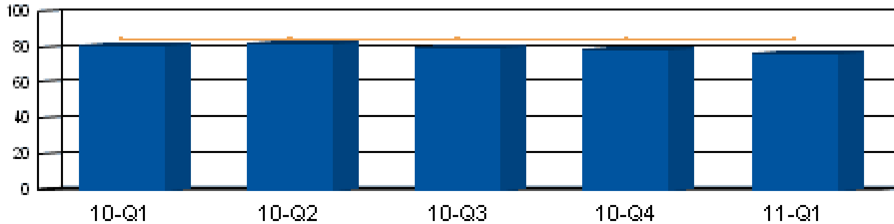
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Non-admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs



	Actual	Target
10-Q1	81	**84**
10-Q2	82	**84**
10-Q3	80	**84**
10-Q4	78	**84**
11-Q1	76	**84**

Interpretation - Patient and Business:

Patient Perspective: Based on Q1 results the ED is slightly below the target wait time for the non-admitted low acuity patients. 24% of patients in this category have a LOS greater than 4 hours. However, Physician Initial Assessment time is under the 2.42 hour target which indicates delays in meeting the target for some patients is turn-around time for test results, time needed for treatment and delays in reassessment. Infrequently, patients do have to wait in the waiting room for an available place to be further assessed after triage.

Business Perspective: This target is associated with Pay for Results funding but funding is not solely dependant on this indicator.

Implementation of the EDIS in March is helping to monitor turn-around time for test results and promote more timely reassessment.

Volumes were higher this fiscal compared to last.

Actions & Monitoring Underway to Improve Performance:

The creation of an e-track in section E was open daily from 0800 to 2000. Most days 50% of all patients presenting to the ED were seen in etrack which has significantly contributed to the trend toward meeting this target. When the inpatient Mental Health Program moved to KGH in June, Section E was modified to be used for MH patients. The fast-track was then moved to Section B. At first this was successful, however, after MH volumes started to increase, there was an overflow of patients from E to B. As well, Section E is only staffed 8 hours a day. This has had a negative impact on our ability to see patients in this category due to lack of space. An increase in higher acuity volumes combined with the number of admitted patients waiting for beds has forced more patients to wait in the waiting room for a space to become available.

The implementation of the Emergency Department Information System (EDIS) will help us to continuously monitor ED wait times in real time.

Definition: There are three ED wait time metrics that are directly tied to the Provincial ED Pay for Results initiative which is focused on reducing ED wait times. The MOH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization.
This measure represents the percentage of non-admitted low acuity patients treated within a wait time target of less than 4hrs (CTAS 4 & 5). The 4 hour wait time target is measured from the time of registration in ED to the time the patient leaves the ED.

(Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 66%, Target 09/10: 76%, Target 10/11: 84%, Target 11/12: 84%.

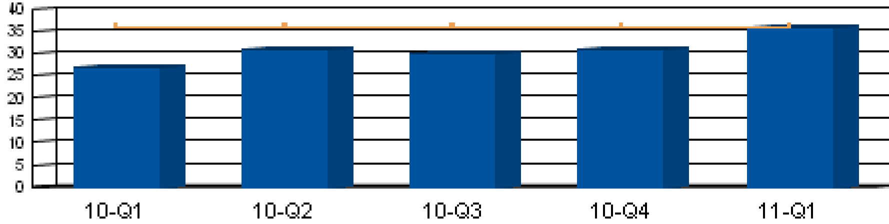
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs



	Actual	Target
10-Q1	27	**36**
10-Q2	31	**36**
10-Q3	30	**36**
10-Q4	31	**36**
11-Q1	36	**36**

Interpretation - Patient and Business:

Patient Perspective: Based on Q1 results, improvements have been made over this past year. While many patients are waiting longer than 8 hours before reaching their inpatient bed, 36% are moving within the 8 hour target.
Those that wait longer than 8 hours are waiting an average of 18.7 hours at the 90th percentile. Inpatient days in ED this quarter were 719.

Business Perspective: When the ED becomes backed up with admitted patients it negatively impacts the ability to see and treat emergency patients from a space and resource perspective. The number of isolations admitted and the ability to quickly move these patients to an inpatient bed further delays the flow of all patients.

Funding from the provincial Pay for Results program will enable us to put initiatives in place to continue to sustain gains made and continue to improve patient flow.

Actions & Monitoring Underway to Improve Performance:

With the goal of achieving the ministry target, a short stay medicine unit opened on Connell 3 in September 2010. Surgery also opened a SSU later in September. Additional flex capacity has been built in.

KGH continues to be part of the Provincial Pay for Results Program for the 4th consecutive year.

Clinical teams are engaged in planning discharges from the point of admission; and making changes with prediction of discharge dates and activation of conditional discharge orders at earliest point in the day with goal of having discharges occur as quickly as possible after the order is written.

Some patients do not get admitted until after the 8 hour target has passed, for various reasons including long waits for consult or a delay in the decision to admit.

A drop in the number of discharges occurring on the weekends causes predictable bottlenecks in ED on Monday mornings. The early part of the week is spent "catching up".

The implementation of the Emergency Department Information System (EDIS), on March 5, will help us to continuously monitor ED wait times in real time.

Definition: This is the length of time a patient admitted to hospital is in the ED waiting for an inpatient bed The MOH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization. This measure represents the percentage of admitted patients (from the ED) with a length of stay LOS of <8 hrs. The 8 hours is measured from the time the patient is registered in the ED to the time that the patient is moved into an inpatient bed.

Target: Baseline 08/09: 27%, Target 09/10: 37%, Target 10/11: 36%, Target 11/12: 36%.

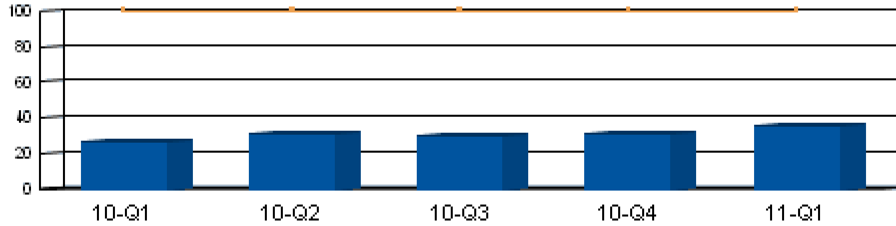
Kingston General Hospital

Milestone #7

SD1 Transform the patient experience through a relentless focus on quality, safety and service

The ED wait time for admitted patients is less than 8 hrs for 100% of patients

Indicator: Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)



	Actual	Target
10-Q1	27	**100**
10-Q2	31	**100**
10-Q3	30	**100**
10-Q4	31	**100**
11-Q1	36	**100**

Interpretation - Patient And Business:

While we are meeting the Pay for Results target of 36 percent of all admitted patients to an inpatient bed within 8 hours, we are not meeting the 100 percent target set by KGH.

Many patients require longer than 8 hours for assessment, consultation and decision to admit. For these patients, we created a virtual CDU to avoid breeching the 7 hour target for non-admitted patients. In this model, it is acceptable to admit 30% of patients from CDU. These patients can be in CDU for up to 24 hours but will necessarily breech the 8 hour target.

Having the option of CDU allows more time for diagnosis and treatment and possible admission avoidance.

Actions & Monitoring Underway to Improve Performance:

All additionally funded beds have been opened included short stay beds in both Medicine and Surgery, express beds and flex capacity has been created.

Surgery has closed appropriate beds reflective of LOS targets.

Staffing the flex beds and overcapacity beds has been challenging and has contributed to delays in moving patients to these beds.

Definition: This is the length of time a patient admitted to hospital is in the ED waiting for an inpatient bed The MOH provides financial support to select hospitals to improve on ED wait times – decreasing ED demand, increasing ED capacity and improving bed utilization. This measure represents the percentage of admitted patients (from the ED) with a length of stay LOS of <8 hrs. The 8 hours is measured from the time the patient is registered in the ED to the time that the patient is moved into an inpatient bed.

Target: SSC Target 100%

Strategy milestone 8

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Transform the patient experience through a relentless focus on quality, safety and service	All preventable delays in the patient journey to, within, and from KGH are eliminated	Reduce wait times
Indicator(s)		**Status**
Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets		Red

1. **What are the contributing factors?**

   Ministry initiatives initially targeted at select surgical groups has created differential access and resource challenges for other surgical disciplines, which as a result, has negatively impacted the ability to achieve certain wait time targets. Expansion of mandatory public reporting of wait times for all elective surgeries has created a greater awareness of the problem.

2. **Are we on track to meet the milestone?**

   As of Q1, we are at risk of not achieving this milestone. 37 of 46 (80%) wait time categories were meeting the MOH 90th percentile wait time targets. It is worth noting that an aggressive target has been set for achieving this milestone. Although the status is currently "Red" there has been a 13% improvement over the last 2 quarters in the number of categories meeting target and as a result we are 10% (4 additional services) away from meeting target. Adult orthopedic surgery (excluding total joint replacements), adult plastic and reconstructive surgery and abdominal aortic aneurysm surgery are major areas of concern. MRI wait times which are still above target, have shown a 40% improvement over the last 2 quarters.

3. **Actions planned/underway**

   The surgical program closely monitors wait times with the Wait Time Committee. A realignment of OR time scheduled across the 7 day week for the fall of 2011 will help with optimizing OR utilization and therefore case throughput. Stabilized staffing and process improvements have helped decrease MRI wait times. As a result, further reductions are anticipated.

KGH Kingston General Hospital

Milestone #8

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	Trend
SD1 Transform the patient experience through a relentless focus on quality, safety and service	90% of patients receive their elective surgery within or faster than the provincially targeted wait time		All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			All Paediatric Surgery - 90th Percentile Wait Time (Days)	Y	R	R	R	R	↑
			Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
			Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angioplasty - 90th Percentile Wait Time (hrs)	G	G	G	G	G	↑
			Diagnostic Imaging - CT – 90th Percentile Wait time (Days)	G	G	G	G	G	↑
			Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)	R	R	R	R	R	↑
			General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	R	R	G	G	G	↓
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	R	R	R	G	G	↓
			Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets				R	R	↑
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

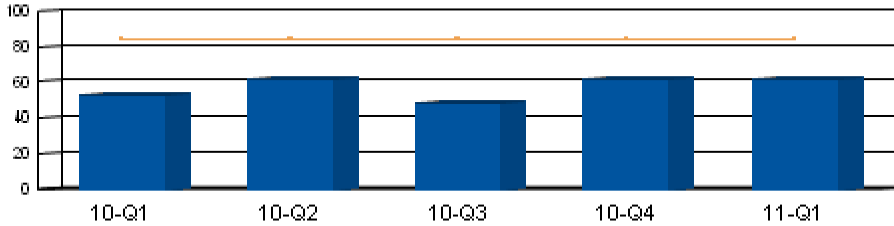
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	52	**84**
10-Q2	61	**84**
10-Q3	48	**84**
10-Q4	62	**84**
11-Q1	61	**84**

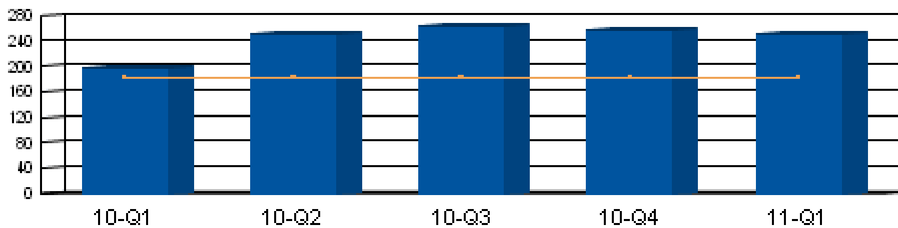
Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For all confirmed and suspected cancer surgical procedures, Cancer Care Ontario and the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or exam ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 64 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days.

Indicator: All Paediatric Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	197	**182**
10-Q2	250	**182**
10-Q3	263	**182**
10-Q4	258	**182**
11-Q1	250	**182**

Interpretation - Patient and Business:

Challenges have existed with reduced pediatric surgeon coverage to meet volumes.

Actions & Monitoring Underway to Improve Performance:

Second 0.5 FTE pediatric surgeon hired and started August 1st, 2011, bringing the service coverage back to a full 1 FTE.

Definition: For children 18 years and under having surgical procedures, the Ontario WTS measures the wait time from when a patient and a surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

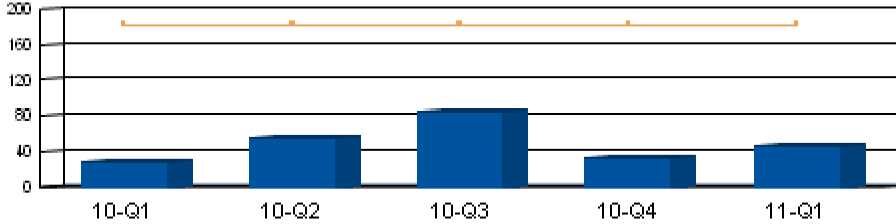
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	29	**182**
10-Q2	56	**182**
10-Q3	85	**182**
10-Q4	33	**182**
11-Q1	46	**182**

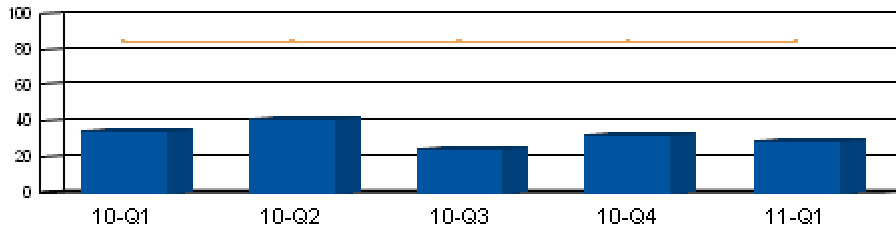
Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: For cardiac surgeries, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 78 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days

Indicator: Coronary Angiography - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	34	**84**
10-Q2	41	**84**
10-Q3	24	**84**
10-Q4	32	**84**
11-Q1	29	**84**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Coronary angiography means taking pictures of blood vessels in the heart. Angiography involves injecting a dye that is visible to x-rays. The physician, a cardiology interventionalist, uses an x-ray machine to guide him or her through the procedure and record the pictures. For coronary angiography procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventionalist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait time is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment. .
Note: Wait Time information is shown only for referrals where the primary indication is coronary artery disease. These account for >85% of total angiography referrals.

Target: Baseline 08/09: 39 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days.

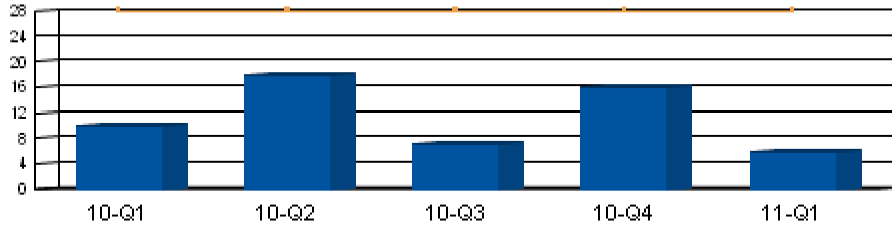
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Coronary Angioplasty - 90th Percentile Wait Time (hrs)



	Actual	Target
10-Q1	10	**28**
10-Q2	18	**28**
10-Q3	7	**28**
10-Q4	16	**28**
11-Q1	6	**28**

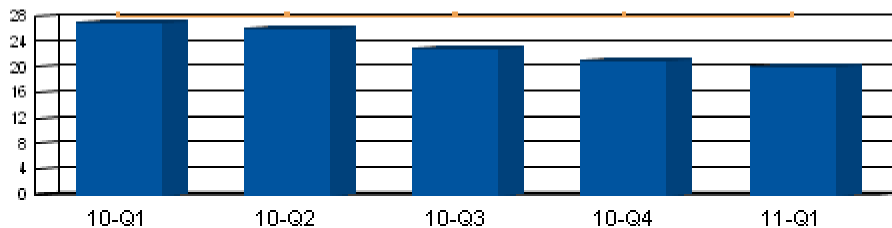
Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery. For coronary angioplasty procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventional cardiologist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment.

Target: Baseline 08/09: 12 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days.

Indicator: Diagnostic Imaging - CT – 90th Percentile Wait time (Days)



	Actual	Target
10-Q1	27	**28**
10-Q2	26	**28**
10-Q3	23	**28**
10-Q4	21	**28**
11-Q1	20	**28**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Actions & Monitoring Underway to Improve Performance:

Excellent standing in the province, will monitor and maintain

Definition: For diagnostic CT scans, the Ontario Wait Time Strategy measures the wait time from when a CT scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported CT wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 26 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days.

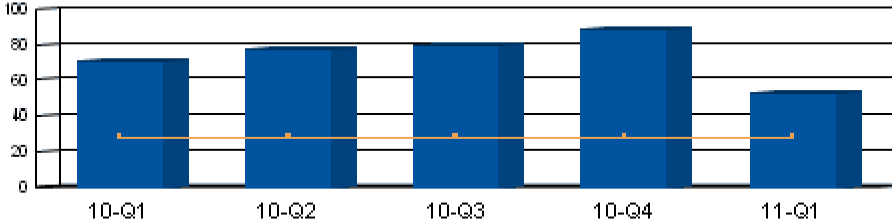
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)



	Actual	Target
10-Q1	70	**28**
10-Q2	77	**28**
10-Q3	80	**28**
10-Q4	89	**28**
11-Q1	53	**28**

Interpretation - Patient and Business:

Even though we are still above the provincial target of 28 days, KGH has made great progress in decreasing the MRI wait time.

With the addition of a 4th full time position finally being filled the during the 2nd quarter, 3rd and 4th quarters of the year should dramatically decrease this number.

Provincial average 97 days

LHSC: 37 days
UHN: 97 days
The Ottawa Hospital: 139 days
Hamilton Health Sciences: 197 days

Kingston General Hospital: 53 days

Actions & Monitoring Underway to Improve Performance:

Continue to expand hours and improve efficiency thereby decreasing the time to service for the patient population of KGH.

Definition: For diagnostic MRI scans, the Ontario Wait Time Strategy measures the wait time from when a diagnostic scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported MRI wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 120 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days

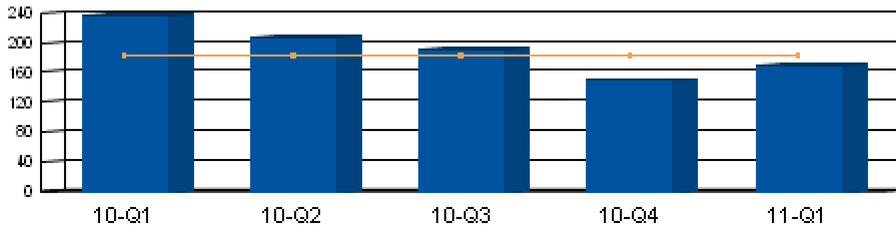
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	237	**182**
10-Q2	207	**182**
10-Q3	192	**182**
10-Q4	149	**182**
11-Q1	169	**182**

Interpretation - Patient and Business:

Additional allocated OR schedule times continue to positively influence this trending.

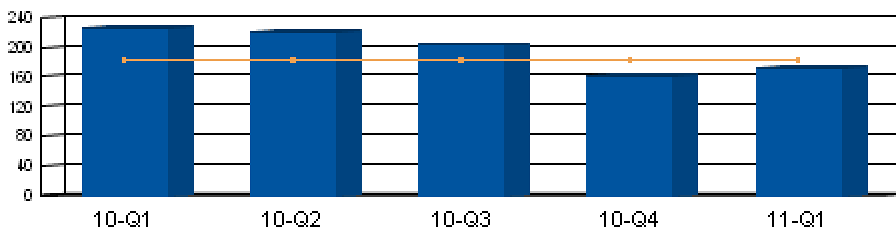
Actions & Monitoring Underway to Improve Performance:

Maintaining a balanced and appropriately distributed operative time schedule will be key with improving this positive trending.

Definition: For all general surgical procedures (excluding confirmed and suspected cancer surgeries), the Ontario WTS measures the wait time from when a patient and a surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 306 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

Indicator: Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	225	**182**
10-Q2	221	**182**
10-Q3	203	**182**
10-Q4	161	**182**
11-Q1	173	**182**

Interpretation - Patient and Business:

Continues to trend positively due to extra initiatives such as the implementation of the HDH Hip and Knee Short Stay program.

Actions & Monitoring Underway to Improve Performance:

OR management will continue to monitor and evaluate ability to meet volumes on a monthly basis to ensure the ability to staying below target. New baseline target volumes and extra operative room hours starting in September will assist in keeping this indicator trending positively.

Definition: For all total hip and knee replacement procedures, the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 403 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

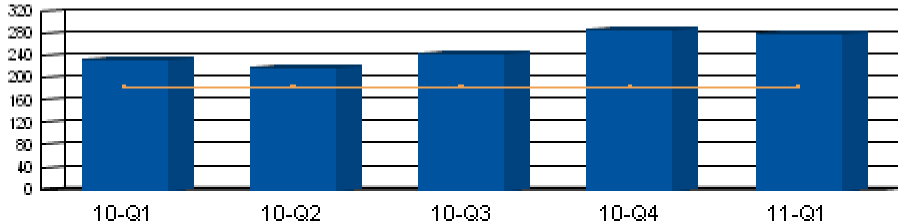
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)



	Actual	Target
10-Q1	233	**182**
10-Q2	217	**182**
10-Q3	242	**182**
10-Q4	286	**182**
11-Q1	281	**182**

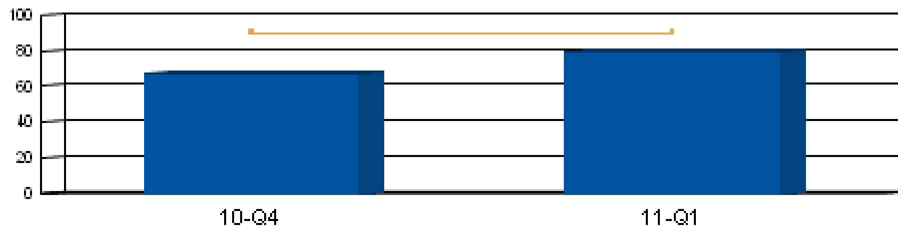
Actions & Monitoring Underway to Improve Performance:

Wait times will continue to be monitored at the joint KGH/HDH Wait list committee meetings. With the additional operative time being available in September for the ortho service it is hoped that these wait times will trend more positively.

Definition: For orthopedic surgery (excluding total hip and knee replacements) procedures, the Ontario WTS measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.

Target: Baseline 08/09: 183 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

Indicator: Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets



	Actual	Target
10-Q4	67	**90**
11-Q1	80	**90**

Interpretation - Patient And Business:

The Ontario government has put a plan in place to increase access and reduce wait times for most surgeries. Ontario's plan has a goal to significantly increase the number of procedures to reduce the backlog that has developed over the last decade, standardize best practices for both surgical and administrative functions in order to improve patient flow and efficiency and collect and report accurate and up-to-date data on wait times to allow better decision making and increase accountability.

Actions & Monitoring Underway to Improve Performance:

Although the Q1 data has not reached target there has been a 20% improvement in patients receiving timely access to scheduled surgery from the previous quarter. The surgical program leadership closely monitors wait times in conjunction with the Wait Times Committee. Departments and Divisions are informed of their rates and encouraged to look at means to improve wait times.

Definition: The Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from ""decision to treat"" to ""treatment"". For wait times that are reported for the specific time period, calculations include all cases where the surgery or (""treatment"") was completed during that time period. The wait times are calculated by subtracting the ""decision to treat"" date from the ""treatment"" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed surgery.
The KGH is mandated to report 90th percentile wait times in 40 unique categories to the MOH on a monthly basis. This performance indicator simply counts the number of those unique categories meeting the 90th percentile target and dividing that by the total number of unique categories expressed as a percentage. It is intended to provide an overall view of progress with respect to meeting MOH wait time targets.

Target: Target 11/12: 90%

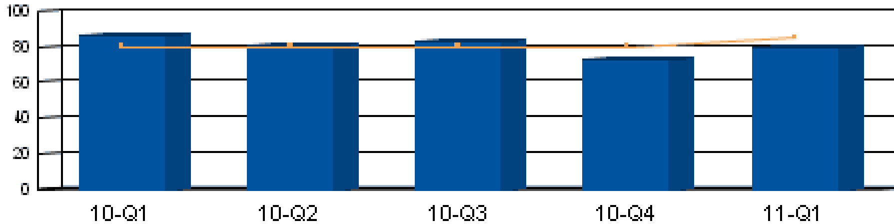
Kingston General Hospital

Milestone #8

SD1 Transform the patient experience through a relentless focus on quality, safety and service

90% of patients receive their elective surgery within or faster than the provincially targeted wait time

Indicator: Radiation Wait time (Referral-Consult) Percent seen within 14 days



	Actual	Target
10-Q1	86	**80**
10-Q2	81	**80**
10-Q3	83	**80**
10-Q4	73	**80**
11-Q1	79	**85**

Interpretation - Patient and Business:

Q1 results show an overall wait time of 79.4% of new patients referred to KGH for a consultation with a radiation oncologist were seen within 14 days of referral. The 2011/12 target is 85%.

Actions & Monitoring Underway to Improve Performance:

Referral to consultation wait times for new radiation patients is closely monitored on a weekly basis by the Radiation Treatment Program at KGH. Action is taken to ensure all unnecessary delays are eliminated to the extent possible in order to maintain timely access to consult with a Radiation Oncologist.

Definition: Cancer Care Ontario (CCO) reports the proportion of patients who are being seen or receiving radiation treatment within the recommended timeframe or target. Referral to Consult: The time between a referral to radiation oncologist to the time that oncologist consults with the patient. This is based on the waiting period from the time a regional cancer centre receives a referral for a patient to have their initial consultation appointment with the oncologist. KGH's 2009/10 target is 75%. The provincial target/benchmark for radiation referral to consult is 80% of patients are seen within 14 days of receipt of the referral to the regional cancer centre. This region specific target is established on an annual basis with CCO before the end of Q4 of the previous year.

Target: Target 09/10: 80%, Target 10/11: 80%, Target 11/12: 80%.

Strategy milestone 9

100% of our clinical areas have implemented ICPM

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Bring to life new models of interprofessional care and education	Our Interprofessional Collaborative Practice Model (ICPM) is implemented in every clinical area with high ratings from patients, staff and learners	Roll out the KGH model of interprofessional collaborative practice in every clinical area
Indicator(s)		**Status**
Implementation of Interprofessional Collaborative Practice Model in all inpatient units and extended to ambulatory settings by March 2011		Green

1. **What are the contributing factors?**

   The ICPM Steering Committee is on track with planning extension of the model to ambulatory areas. The indicator is written as all or none and will not be fully achieved until end of year

2. **Are we on track to meet the milestone?**

   Yes. The target could be adjusted to reflect the quarterly plan for rollout that ensure all areas implemented by end of fiscal year.

3. **Actions planned/underway?**

   - For Q2 - Endoscopy; Outpatient Procedure Unit; Post Anaesthetic Recovery Unit and Same Day Admission Centre
   - For Q3 - Renal (KGH and Kingston); Diagnostic Imaging; Labs; Operating Room; Belleville/Picton/Perth Smiths Falls Satellite Dialysis
   - For Q4 - Ambulatory Ob/Gyne, Cardiac and ED Programs; Sleep lab/EEG/EMG/Ventilator Equipment Pool; Asthma Education; Peritoneal Dialysis unit and Stem Cell; Cancer Centre

   Evaluation measures are part of the implementation plan and include satisfaction rankings. ICPM Steering continues oversight of evaluation measures of inpatient units, and makes adjustments where indicators expose need or opportunity. It is of note that the ICPM rollout to date has met all timelines, and demonstrates improved patient satisfaction measures and many quality/efficiency measures. Staff satisfaction measures do not yet show consistent or sustained improvement.

KGH Kingston General Hospital

Milestone #9

				10-Q4	11-Q1
SD2 Bring to life new models of interprofessional	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012	R	G

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

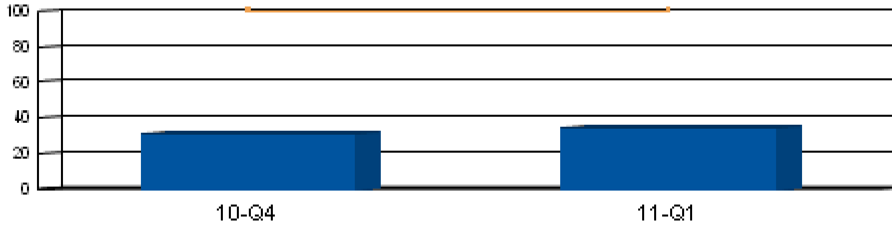
Kingston General Hospital

Milestone #9

SD2 Bring to life new models of interprofessional care and education

100% of our clinical areas have implemented ICPM

Indicator: Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012



	Actual	Target
10-Q4	31	**100**
11-Q1	35	**100**

Interpretation - Patient and Business:

Between November 2009 and April 2011, ICPM was implemented in all inpatient care areas (n=18). The plan for fiscal year 2011/12 is to implement ICPM in outpatient and ambulatory care areas (n=33).

Actions & Monitoring Underway to Improve Performance:

Evaluation of five inpatient units is ongoing and evaluation of eight outpatient and ambulatory care units is planned.

Definition: Percent completion of ICPM implementation in 51 patient care areas. ICPM implementation is defined as putting into action all role, process improvement, documentation, technology and staffing changes following stakeholder engagement and completion of staff and physician education. The evaluation strategy is approved and in progress.

Target: Target 11/12: 100%

Kingston General Hospital

Strategy milestone 10

The KGH Interprofessional Education Steering Committee and workplan is in place

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Bring to life new models of interprofessional care and education	KGH is recognized as a centre of excellence in interprofessional education	Establish an Interprofessional Education Steering Committee

Indicator(s)	Status
IPE Work Plan Launched	Green

1. **What are the contributing factors?**

   IPE Steering Committee was launched in May using Terms of Reference endorsed by EMC and shared with Research and Education Committee of the Board. The committee has met twice over the summer months. There is active interest and engagement of all members delivering on the expectations outlined in the strategy. The project has infrastructure support with the Project Manager as well as administrative support .

2. **Are we on track to meet the milestone?**

   Yes. A charter has been drafted along with Terms of Reference for support teams.

3. **Actions planned/underway?**

   The draft charter and terms of reference for the support teams (Accreditation; Communication; Environmental Factors & Support; IPE Events Planning) and IPE Evaluation Committee are expected to go to the Operations Committee for review and endorsement by early September. Some activities underway (event planning).

Kingston General Hospital

Milestone #10

				10-Q4	11-Q1
SD2 Bring to life new models of interprofessional	The KGH Interprofessional education council		IPE Work Plan Launched	G	G

Indicates worsening performance to target over the past 5 quarters Indicates worsening performance to target over the past 5 quarters

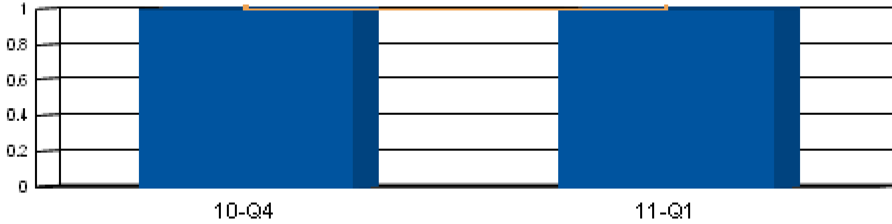
Kingston General Hospital

Milestone #10

SD2 Bring to life new models of interprofessional care and education

The KGH Interprofessional education council and work plan is in place

Indicator: IPE Work Plan Launched



	Actual	Target
10-Q4	1	**1**
11-Q1	1	**1**

Interpretation - Patient and Business:

The work plan is in place and the terms of reference for the Evaluation Committee, Accreditation Alignment Team, Communication Team, Environmental Factors and Support Team and the Interprofessional Events Planning Team have been drafted.

Actions & Monitoring Underway to Improve Performance:

The terms of reference will be presented to the IPE Steering Committee for approval in August.

Definition: The IPE project charter forms the basis of the IPE work plan. The work plan includes establishment of working groups with defined terms of reference, objectives and deliverables, initiative timelines, project milestones, and the IPE communication and evaluation strategies.

Target: Target 11/12: Yes

Strategy milestone 11

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	Expand the number of clinician scientists conducting research at KGH

Indicator(s)	Status
Expand Number of Clinician Scientists	Green
Percent Increase of Externally Funded Research Dollars at KGH	Green
Research Institute Business and Operating Plan Delivered	Green

1. What are the contributing factors?

All three indicators reported on an annual basis. Quarterly clinical trials indicators all green.

2. Are we on track to meet the milestone?

Yes. All three indicators are on track to be well above target by year end. First competition of the SEAMO Clinician Scientists Recruitment Program occurred in Spring 2011.There are 3 potential clinician scientist candidates under review with impact analyses underway. Of note, this is being done collaboratively among KGH, Queen's University and SEAMO. Also of note, three researchers were awarded $1.43M in latest CIHR Competition and another achievement was the KGH Inaugural Research Showcase which occurred May 18th-20th, 2011.

3. Actions planned/underway?

Actual F2012 data for research dollars will not be available until September 2012; will need to use F2011 data for reporting of F2012 as 95% of data is obtained from external sources; results will come out in Fall 2011.Preliminary needs assessment for Research Institute completed; includes draft floor plan for new potential "*clinical investigation unit". Actively* involved with current and future space planning with JPO. Commencing in the 2011-12 fiscal year, $3.6 M will be capitalized annually by SEAMO to fund 2 to 3 new clinician scientist positions of 5 years duration, creating over a 5 year period 10-15 new clinician scientist positions at the various hospital institutions.

Kingston General Hospital

Milestone #11

Strategic Direction	Objective		Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Active Clinical Trials	G	G	G	G	G
			Clinical Trials Generating Revenue	G	Y	Y	G	G
			Expand Number of Clinician Scientists	N/A	N/A	N/A	N/A	G
			New Clinical Trials	G	G	G	G	G
			Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	N/A	N/A	N/A
			Research Institute Business and Operating Plan Delivered	N/A	N/A	N/A	N/A	N/A

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

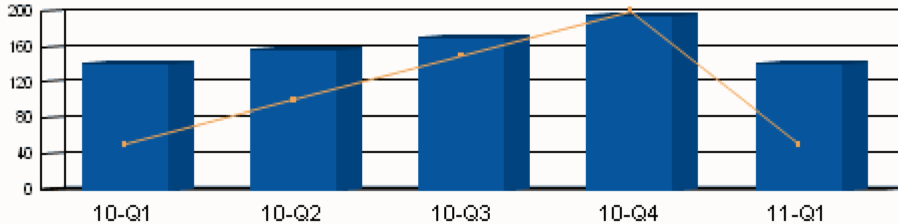
Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Active Clinical Trials



	Actual	Target
10-Q1	140	**50**
10-Q2	156	**100**
10-Q3	170	**150**
10-Q4	196	**200**
11-Q1	140	**50**

Interpretation - Patient and Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q1.

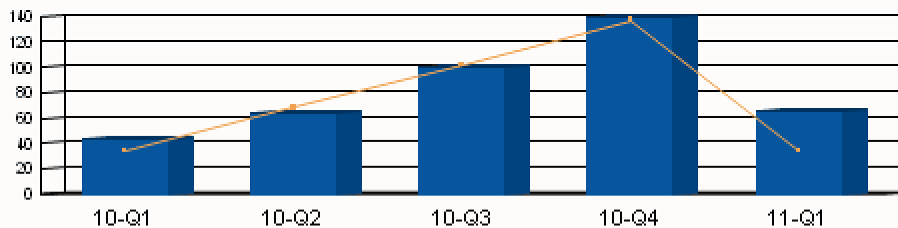
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the first quarter (Q1).

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition, total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 195 Trials, Target 09/10: 200 Trials (2.5% increase), Target 10/11: 200 Trials. Target 11/12: 200 Trials.

Indicator: Clinical Trials Generating Revenue



	Actual	Target
10-Q1	44	**34**
10-Q2	64	**68**
10-Q3	100	**102**
10-Q4	139	**137**
11-Q1	66	**34**

Interpretation - Patient and Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q1.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the first quarter (Q1). There is a widespread decline in industry sponsored clinical trials by 15% in North America. Additionally, researchers are only compensated by industry sponsors per patient visits, therefore the time to enrolment to first patient seen may delay a clinical trial generating revenue in a particular quarter. Local lack of public/patient/staff awareness regarding participation in clinical trials may also hinder trials generating revenue if subject enrollment is an issue. As per our Affiliation Agreement with Queen's University, clinical trial contracts are administered by the Office of Research Services (ORS) Contracts Office. KGH Office of Health Sciences continues to work with Queen’s ORS Contracts Office and Queen's Department of Financial Services to decrease the process time for initiating clinical trials. In Spring 2011 the electronic HSREB submission process went live which will help expedite the approval process for all research projects, including clinical trials.

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 125 Trials, Target 09/10: 137 Trials (10% increase), Target 10/11: 137 Trials. Target 11/12: 137 Trials.

Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Expand Number of Clinician Scientists

	Actual	Target
11-Q1	1	**1**

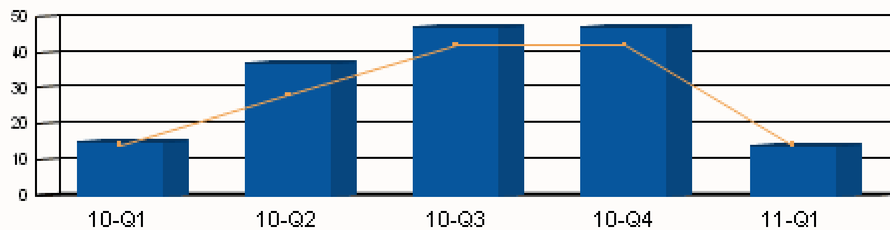
Interpretation - Patient and Business:

First competition of the SEAMO Clinician Scientists Recruitment Program held in spring 2011. Three (3) potential clinician scientist candidates may come to KGH conditional upon Hospital impact analysis.

Definition: Commencing in the 2011-12 fiscal year, $3.6 million dollars will be capitalized annually to fund 2 to 3 new clinician scientist positions of 5 years duration within the Queen's Faculty of Health Sciences, creating over a 5 year period 10-15 new clinician scientist positions. Some of these clinician scientists will reside in KGH. The new SEAMO Clinician Scientists Recruitment Program supports SEAMO's objective of significantly expanding its clinical research enterprise by increasing SEAMO's clinical scientist research capacity. A clinician scientist is defined as a physician who leads, or is deemed to have the potential to lead, a research program that is supported by sustained funding from external agencies.

Target: Target = 1 or greater in 11/12

Indicator: New Clinical Trials



	Actual	Target
10-Q1	15	**14**
10-Q2	37	**28**
10-Q3	47	**42**
10-Q4	47	**42**
11-Q1	14	**14**

Interpretation - Patient and Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q1.
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the first quarter (Q1). As per our Affiliation Agreement with Queen's University, clinical trial contracts, agreements and grants are administered by the Office of Research Services' Contracts Office.

Definition: The Council of Academic Hospitals of Ontario (CAHO) is moving to adopt research as the defining characteristic of an academic hospital. Research attracts the most highly qualified staff, it helps to build public and patient confidence, it drives evidence based care, and it provides local access to clinical trials, new treatment modalities and technologies. In order to be considered an academic hospital under the CAHO definition total research funding attributable to the hospital must exceed $10M. In depth reporting on research activity and funding at KGH is provided annually in the 'Annual Research Report' in the Fall of the subsequent fiscal year. However, various indicators related to clinical trials activity can and will be provided on a quarterly basis.

The majority of clinical trials within KGH are funded through external granting agencies (i.e. CIHR) or industry/corporation sponsors.

Target: Baseline 08/09: 53 Trials, Target 09/10: 56 Trials (5% increase), Target 10/11: 56 Trials. Target 11/12: 56 Trials.

Kingston General Hospital

Milestone #11

SD3 Cultivate patient oriented research

Externally funded research at KGH has increased by 10% and our clinician scientist program expands

Indicator: Percent Increase of Externally Funded Research Dollars at KGH

	Actual	Target
11-Q1		10

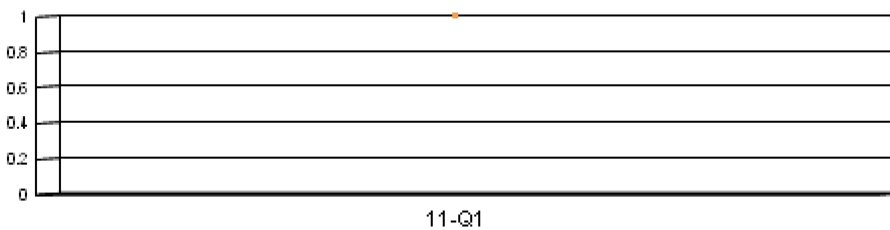
Interpretation - Patient and Business:

Performance indicator is only available on an annual basis and will be reported in Q4.

Definition: The KGH 2015 Strategy Plan calls for externally funded research at KGH to increase by 50% by the end of F2015. Researchers at KGH received $15.6 and $16.3 million dollars in external funding from government sources, foundations, societies and agencies, industry, and other sources in F2009 and F2010 respectively.

Target: Target 11/12: 10% increase from 08/09

Indicator: Research Institute Business and Operating Plan Delivered



	Actual	Target
11-Q1		1

Interpretation - Patient and Business:

Performance indicator is only available on an annual basis and will be reported in Q4.

Definition: Kingston General Hospital (KGH) Research Institute (KGHRI) is the research arm of KGH, a teaching hospital fully affiliated with Queen's University. We have already moved forward in a deliberate way with the establishment of the KGHRI entity in F2011, which will provide a platform to help create an environment where patient-oriented research will flourish. The next steps involve the creation of the KGHRI business and operating plans in F2012 for the next 5-10 years.

Target: Plans completed by Q4 in 11/12

Strategy milestone 12

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Participate in the South East LHIN's Clinical Services Roadmap project and create a Cancer Care at KGH strategy

Indicator(s)	Status
KGH Cancer Care Plan in Place	Green
KGH Participation in Clinical Services Roadmap (CSR) Initiatives	Green

1. **What are the contributing factors?**

   The Regional Cancer Program has begun its engagement and formulation of a strategic plan that will align to the KGH 2015 strategy. KGH leadership is active within the steering committee. The SE LHIN Clinical Services Roadmap has completed its first phase of planning development with the generation of an extensive document of end state analysis and operational plans.

2. **Are we on track to meet the milestone?**

   Yes.

3. **Actions planned/underway**

   The KGH Cancer Care strategic planning continues under the program leadership with a wide engagement of stakeholders. The CSR project documentation is time lined for internal review and then regional analysis this fall. Hospitals are reviewing in context of feasibility and resource requirements.

KGH Kingston General Hospital

Milestone #12

				11-Q1
SD4 Increase our focus on complex-acute and specialty care	KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place		KGH Cancer Care Plan in Place	G
			KGH Participation in Clinical Services Roadmap Initiatives	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

Milestone #12

SD4 Increase our focus on complex-acute and specialty care

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Indicator: KGH Cancer Care Plan in Place

	Actual	Target
11-Q1	0	**1**

Interpretation - Patient and Business:

The development of a Cancer Care strategy for KGH kicked off with a broad stakeholder retreat in April 2011, launching a process that mirrors the one used to create the KGH 2015 strategy.

A Steering Committee is in place to oversee the process and provide guidance and input throughout. Eleanor Rivoire is the executive sponsor on this KGH 2015 action plan priority.

The process is on track as of the end of Q1.

Actions & Monitoring Underway to Improve Performance:

Next steps in developing the strategy include a series of mini-retreats or deep dive discussions on particular themes that emerged from the April 2011 retreat (to be set up for early September 2011) as well as a Validation exercise scheduled for September 19, 2011.

Stakeholder engagement to date has been strong with wide spread interest and commitment to a cancer care plan that advances the KGH team's ability to deliver outstanding cancer care, always.

A final Cancer Care strategy is expected by the end of March 2012.

Definition: A plan for Cancer Care at KGH will be in place by the end of March 2012 as articulated in the KGH 2015 Action plan for achieving Outstanding Care, Always. The cancer care plan will consider the strategic directions in the KGH 2015 strategy as well as the priorities articulated in Cancer Care Ontario's Ontario Cancer Plan III and the South East Regional Cancer Program plan. As a guide to the strategic development, choices and investments in cancer care, research and education to 2015, this plan will be instrumental in achieving Outstanding Cancer Care, Always at KGH. The process used to develop the cancer care plan will serve as an example of clinical planning that can be used by others within KGH to map their efforts to the 2015 strategy and action plan.

Target: Target 11/12: Yes

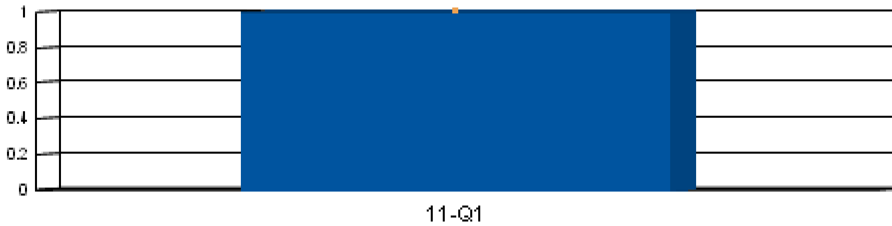
Kingston General Hospital

Milestone #12

SD4 Increase our focus on complex-acute and specialty care

KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place

Indicator: KGH Participation in Clinical Services Roadmap Initiatives



	Actual	Target
11-Q1	1	**1**

Interpretation - Patient And Business:

The SE LHIN and the regional hospitals with CCAC have embarked upon a critical examination of current hospital services within seven clinical areas. The goal is to improve service provision, reduce program duplication and improve access, efficiency and effectiveness. Working groups with representation from all partners have focused on the clinical area of cardiovascular disease, emergency department wait times, healthcare acquired infections, maternal/high risk newborn, mental health and addictions services, restorative care and surgery.

Actions & Monitoring Underway to Improve Performance:

KGH's clinical programs and leadership continue to actively participate in the development of the roadmap.

Definition: KGH’s ability to fulfill its role as the academic tertiary care center to the region in part requires an integrated, strategic approach to health care in the SE LHIN. Regional partners working to their scope, rely on KGH to provide the complex-acute and specialty level care. KGH’s participation and leadership within the clinical services roadmap will help meet this objective. The similar alignment of the Cancer Care strategic plan will similarly meet the same objective for this complex group of patients.

Target: Target 11/12: Yes

Strategy milestone 13

100% of target service volumes are met

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Deliver on MOH volume contracts
Indicator(s)		**Status**
Percent of Wait Time Contracted Volumes Achieved		Red

1. **What are the contributing factors?**

   A balance between the vast population of surgical patients needing surgery not part of the MOH funded programs vs. those that are with limited resources creates a clinical access and prioritization of care challenge.

2. **Are we on track to meet the milestone?**

   As of Q1, we are at risk of not achieving this milestone. Only 4 of 11 volume contracts are on target (2 of 4 general surgical categories, scoliosis repair, and CT hours). Areas of greatest concern at this time are total joint replacements and cholecystetomy. Every effort is being made to maximize Hotel Dieu Hospital capacity in these two areas. Because these are only Q1 results, we anticipate improvements through Q2 and Q3 that would put us back on target. Not achieving these targets by year end poses the risk of these volumes being adjusted downward and permanently reassigned to neighbouring hospitals. This carries a financial risk to the organization.

3. **Actions planned/underway**

   The Wait Time Committee and the Surgical Program are closely monitoring these areas of concern. A realignment of OR time scheduled across the 7 day week for the fall of 2011 will help with optimizing OR utilization and therefore case throughput.

KGH Kingston General Hospital

Milestone #13

			10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met	Stem Cell Transplants	Y	G	Y	G	G	↑
		Ambulatory Care Volumes	G	G	G	G	G	↑
		Cardiac - Angiography Volumes	G	G	G	G	G	↑
		Cardiac - Angioplasty Volumes	G	G	Y	G	Y	↓
		Cardiac - Isolated CABG Volumes	G	G	G	G	G	↑
		Chronic Kidney Disease Program- Weighted Units	G	G	G	G	G	↑
		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
		Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑
		Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
		Hip and Knee Replacement Volume (Wait Time Strategy Allocation)	G	Y	G	G	Y	↓
		Kidney Transplants	G	Y	Y	Y	G	↑
		MRI Hours (Wait Time Strategy Allocation)	G	G	G	R	G	↓
		OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		OR Hours (Inpatient & Outpatient)	Y	Y	Y	Y	G
			Percent of Wait Time Contracted Volumes Achieved					R
			Total Inpatient Admissions	G	G	G	G	G
			Total Inpatient Weighted Cases	G	G	G	G	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

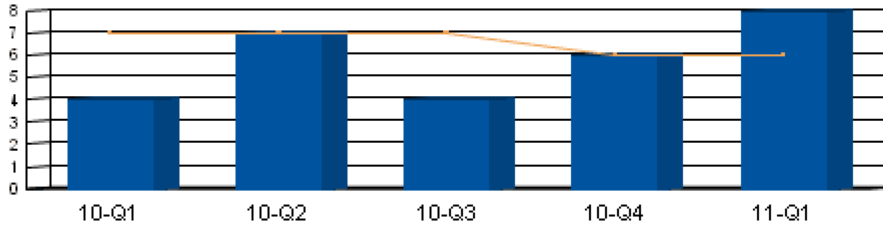
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Stem Cell Transplants



	Actual	Target
10-Q1	4	**7**
10-Q2	7	**7**
10-Q3	4	**7**
10-Q4	6	**6**
11-Q1	8	**6**

Interpretation - Patient and Business:

KGH has established its 2011/12 annual stem cell transplant volume at 25 - 13 cases included in the Hospital's base budget and 12 incremental cases funded by Cancer Care Ontario. In Q1 2011/12, 8 stem cell transplants were completed.

Based on 8 completed transplants in Q1, KGH is still within its base funding for this procedure and has funding capacity over the remaining quarters of 2011/12 to complete 17 additional transplants.

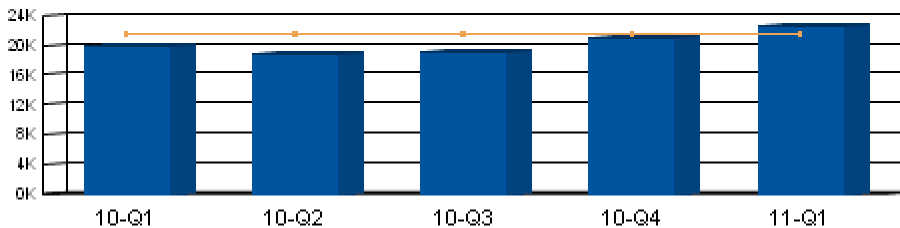
Actions & Monitoring Underway to Improve Performance:

Stem cell volumes are closely monitored to ensure volumes do not exceed available funding.

Definition: Number of Stem Cell Transplants (SCT) is a volume funded program that is currently being monitored by the Ministry of Health and Long Term Care/LHIN and Cancer Care Ontario. Stem Cell Transplants (autologous) require the harvesting of the patient's own stems cells prior to the delivery of high doses of chemotherapy that is intended to target and kill cancer cells present in the blood. Once the chemotherapy has been administered, the patient's own stem cells (previously harvested) are reintroduced into the patient to allow for the generation of new healthy, cancer free stem cells. This is a highly intensive treatment requiring extended hospital stays and specific expertise. Autologous SCTs are known to be effective for patients with myeloma, non-Hodgkin's Lymphoma, Hodgkin's disease and on the rare occasion testicular cancer. The hospital is funded based on the total workload achieved by the program within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA).

Target: Baseline 08/09: 8, Target 09/10: 44, Target 10/11: 44, Target 11/12: 25

Indicator: Ambulatory Care Volumes



	Actual	Target
10-Q1	19855	**21400**
10-Q2	18833	**21400**
10-Q3	19067	**21400**
10-Q4	21050	**21400**
11-Q1	22578	**21400**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total number of ambulatory care visits to the hospital

Target: Baseline 08/09: 85594, Target 09/10: 85594, Target 10/11: 85594, Target 11/12: 85292

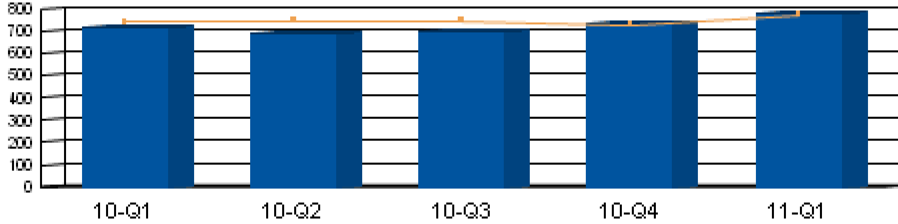
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Angiography Volumes



	Actual	Target
10-Q1	717	**740**
10-Q2	689	**748**
10-Q3	700	**748**
10-Q4	731	**729**
11-Q1	779	**775**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Patient Perspective: There are no concerns as volumes are over target at the end of Q1. This volume meets the patient demand within the region and procedures are being done well within the recommended wait times for all angiography.

Business Perspective: KGH slightly exceeded target at the end of Q1 Funding will be earned to support completed cases and KGH will have achieved the volumes that address demand in the community.

Actions & Monitoring Underway to Improve Performance:

Volumes are monitored monthly and quarterly internally by the Cardiac Program and the Wait list Committee as well as externally by the Cardiac Care Network of Ontario. The data gathered and reported by the CCN allows us to benchmark against peer hospitals within the province and monitor trends across the province.

Definition: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Angiography procedures are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments. Coronary angiography means taking pictures of blood vessels in the heart. Angiography involves injecting a dye that is visible to x-rays. The physician uses an x-ray machine to guide him or her through the procedure and record the pictures to determine whether or not there is adequate blood flow through the vessels.

Target: Baseline 08/09: 1709, Target 09/10: 3100 , Target 10/11: 3100, Target 11/12: 3100

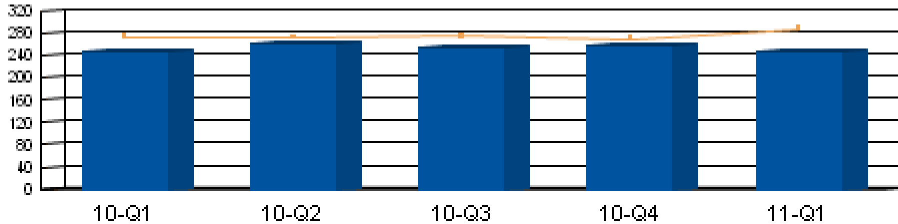
KGH Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
10-Q1	248	**273**
10-Q2	262	**272**
10-Q3	255	**275**
10-Q4	257	**270**
11-Q1	249	**288**

Interpretation - Patient and Business:

Patient Perspective: There are no concerns as volumes are close to target. This volume meets the patient demand within the region and procedures are being done well within the recommended wait times for all angioplasties with virtually no wait list. Most of the angioplasties are completed as part of the diagnostic catheterization procedure. This is referred to as same sitting PCI (percutaneous intervention) or ad hoc. This means that the patient has only one procedure for diagnostic and intervention when appropriate.

Business Perspective: KHG is slightly below target at the end of Q1. Volumes have remained steady and are consistent with last year's volumes. This appears to be the trend across the province. Approximately 33% of angiographies lead to angioplasty which is in line with the provincial average. Funding will be earned to support completed cases and KGH will have achieved the volumes that address demand in the community.

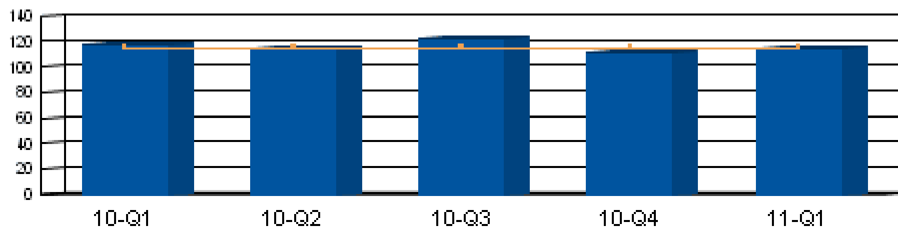
Actions & Monitoring Underway to Improve Performance:

Volumes are monitored monthly and quarterly by the Cardiac Program and Waitlist Committee, as well as monthly by the Cardiac Care Network of Ontario. The information gathered and reported by the CCN allows us to benchmark against peer hospitals within the province and monitor trends across the province.
We still do not know what our funded volumes are for F12

Definition: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Angioplasty procedures are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year LHIN volume adjustments. Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery.

Target: Baseline 08/09: 1084, Target 09/10: 1150, Target 10/11: 1150, Target 11/12: 1150

Indicator: Cardiac - Isolated CABG Volumes



	Actual	Target
10-Q1	117	**115**
10-Q2	114	**115**
10-Q3	122	**115**
10-Q4	112	**115**
11-Q1	115	**115**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Cardiac bypass surgeries are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Target 10/11: 459, Target 11/12: 470

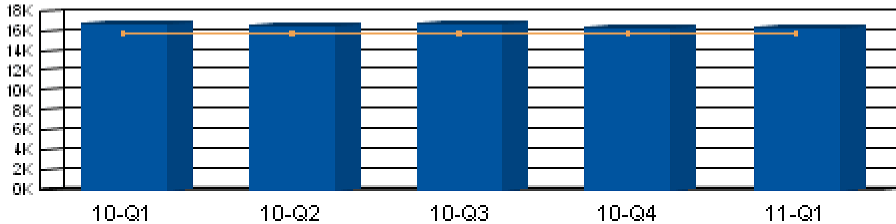
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Chronic Kidney Disease Program- Weighted Units



	Actual	Target
10-Q1	16783	**15655**
10-Q2	16562	**15655**
10-Q3	16723	**15655**
10-Q4	16290	**15655**
11-Q1	16265	**15655**

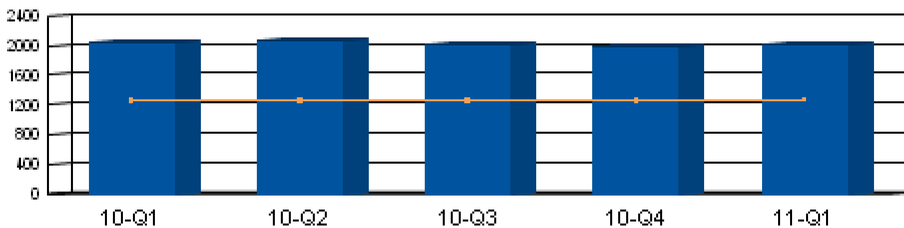
Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Chronic Kidney Disease (CKD) services is a volume funded service that is currently being monitored by Ontario Renal Network (an subdivision of Cancer Care Ontario) on behalf of the Ministry of Health and Long Term Care. The hospital is funded based on the total workload achieved by the service within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA). Activities specified by the HSAA are multiplied by MOH weighted units and then used for funding. Examples of weights: pre dialysis clinic visit = 1.21; level 1 dialysis treatment = 0.68; level 2 dialysis treatment = 1.00. The renal service (within the Medicine Program) delivers care across over 30 measured service points that together comprise the continuum of care for patients with Chronic Kidney Disease. The most familiar care element is that of dialysis.

Target: Baseline 08/09: 65240, Target 09/10: 69992, Target 10/11: 69992, Target 11/12: 69992

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q1	2038	**1247**
10-Q2	2068	**1247**
10-Q3	2009	**1247**
10-Q4	1987	**1247**
11-Q1	2012	**1263**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Actions & Monitoring Underway to Improve Performance:

Will continue to monitor

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. CT Hours is one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Baseline 08/09: 8039 hrs, Target 09/10: 4888 hrs, Target 10/11: 4888 hrs, Target 11/12: 5050 hrs.

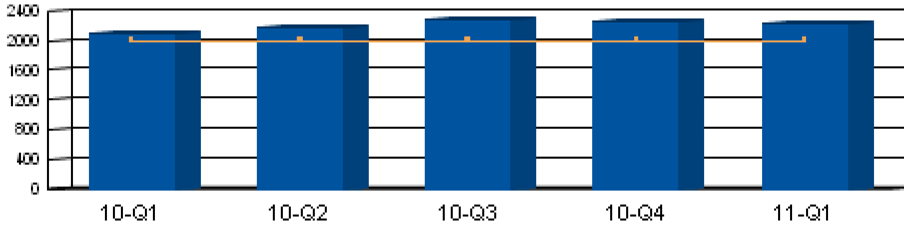
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Emergency Department Admitted Patient Volumes – All Levels of Acuity



	Actual	Target
10-Q1	2095	**2002**
10-Q2	2175	**2002**
10-Q3	2288	**2002**
10-Q4	2250	**2002**
11-Q1	2234	**2002**

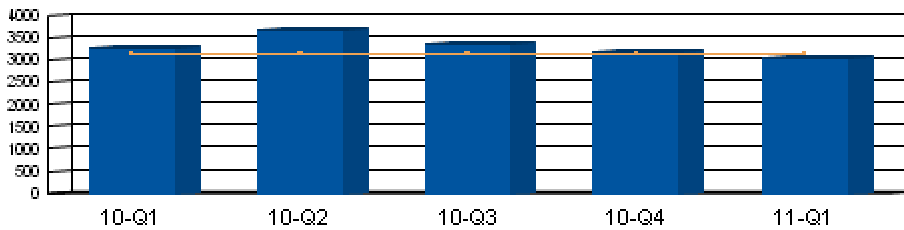
Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of patients in the Emergency Department (ED) (all levels of CTAS acuity) who are admitted and waiting for inpatient bed. (Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 8163, Target 09/10: 8163, Target 10/11: 8163, Target 11/12: 8163

Indicator: Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes



	Actual	Target
10-Q1	3258	**3138**
10-Q2	3691	**3138**
10-Q3	3351	**3138**
10-Q4	3175	**3138**
11-Q1	3058	**3138**

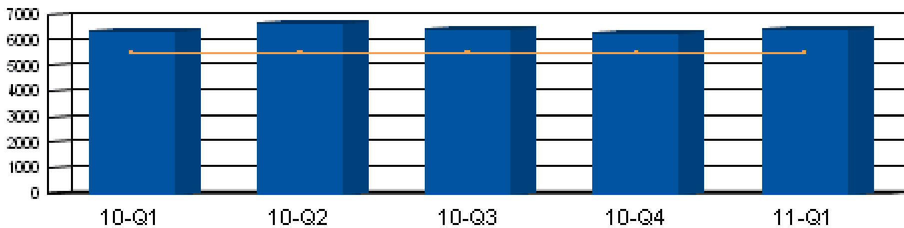
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of Emergency Department (ED) patient visits, low acuity (CTAS 4 & 5) that are seen in the ED and discharged from the ED. (Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 14270, Target 09/10: 14270, Target 10/11: 14270, Target 11/12: 14270

Indicator: Emergency Department Non-Admitted Patient Visits – High Acuity



	Actual	Target
10-Q1	6357	**5481**
10-Q2	6691	**5481**
10-Q3	6421	**5481**
10-Q4	6243	**5481**
11-Q1	6398	**5481**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is the number of Emergency Department (ED) patient visits (high acuity) CTAS (Canadian Triage & Acuity Scale 1, 2 or 3) that are seen in the ED and discharged from the ED. (Note: CTAS – the Canadian Triage Acuity Scale and is a 5 level scale – level1 being the most acute and level 5 the least acute).

Target: Baseline 08/09: 22823, Target 09/10: 22823, Target 10/11: 22823, Target 11/12: 22823

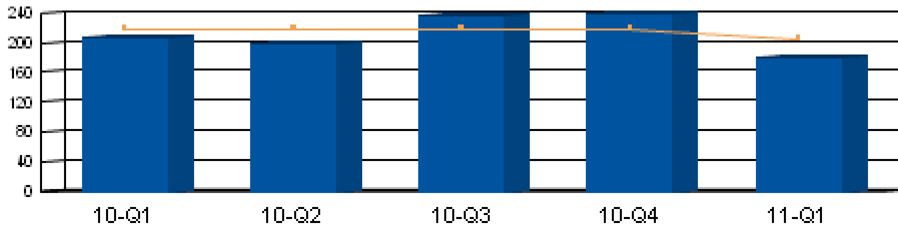
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Hip and Knee Replacement Volume (Wait Time Strategy Allocation)



	Actual	Target
10-Q1	206	**219**
10-Q2	199	**219**
10-Q3	238	**219**
10-Q4	239	**219**
11-Q1	180	**205**

Interpretation - Patient and Business:

As of Q1, hip and knee replacements volumes were behind schedule. It is anticipated that with the adjustments to the OR schedule slated for Q2, PCOP funding, and close monitoring by the SPA program this will be brought back on track.

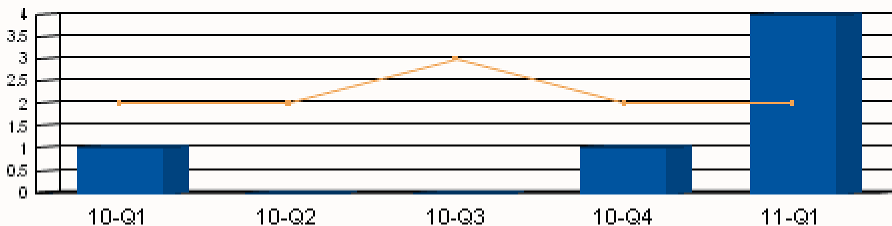
Actions & Monitoring Underway to Improve Performance:

The Wait Time Committee and the Surgical Program are closely monitoring this area of concern. A realignment of OR time scheduled across the 7 day week for the fall of 2011 will help with optimizing OR utilization and therefore case throughput.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. Hip and Knee replacements are one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the Base Volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is Base volumes plus WTS Incremental cases plus any additional in-year LHIN volume adjustments.
The hospital is funded based on the total workload achieved by the program within contracted volumes outlined in the Hospital Services Accountability Agreement (HSAA).

Target: Baseline 08/09: 878, Target 09/10: 876, Target 10/11: 876, Target 11/12: 819

Indicator: Kidney Transplants



	Actual	Target
10-Q1	1	**2**
10-Q2	0	**2**
10-Q3	0	**3**
10-Q4	1	**2**
11-Q1	4	**2**

Interpretation - Patient and Business:

In Q1 we have achieved 4 kidney transplants. The transplant volume is based on available donors and matching recipients.

Actions & Monitoring Underway to Improve Performance:

This is good news for the Renal service and the recipients, however the volume can fluctuate significantly, again dependent on the available organ volume.

Definition: Kidney transplant is at KGH is cadaveric only, and can only occur when a donor is presented and a patient match (within catchment area) is found. If there is no organ match then the organ is made available to the province and beyond. The activity is measured by the case (transplanted kidney). The cadaveric (deceased donor) transplantation of Kidney's is supported by the Trillium gift of life network, the provincial organ and tissue donation agency.

Target: Baseline 08/09: 10, Target 09/10: 9, Target 10/11: 9, Target 11/12: 9

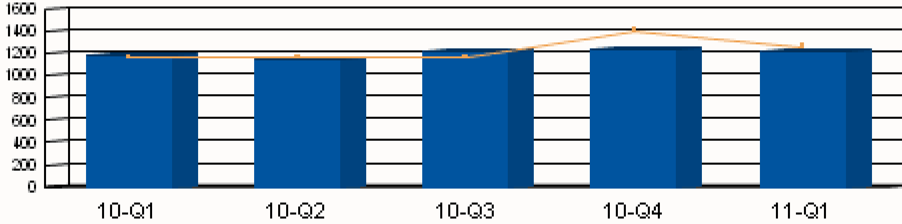
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q1	1189	**1165**
10-Q2	1155	**1165**
10-Q3	1225	**1165**
10-Q4	1232	**1405**
11-Q1	1212	**1259**

Interpretation - Patient and Business:

Focus on maintaining the operational hours has proven to be effective. The 2nd quarter may show a slight decrease in hours as one technologist has left the area at the end of the 1st quarter. However KGH was fortunate to hire another MRI technologist and she will be fully orientated by the 3rd quarter and the department will be working expanded operational hours again.

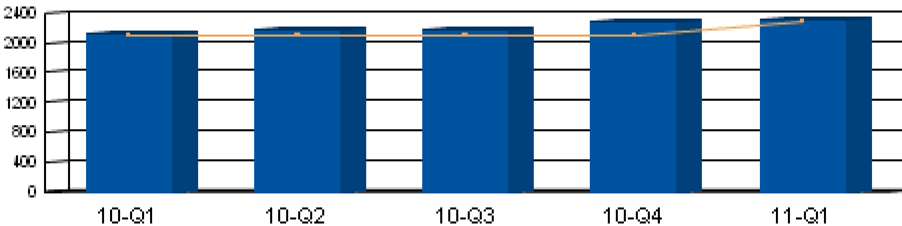
Actions & Monitoring Underway to Improve Performance:

The 2nd quarter is when the majority of the vacation hours will be taken. As well, the new MRI technologist will be orientating during this time period. The department will be working expanded hours during the third and 4th quarters which should allow the KGH MRI department to achieve the targeted WTIS hours by March 2012.

Definition: Wait Time Strategy (WTS) Allocation: In order to strategically increase service in select clinical services the Province has provided funds to support expanded volumes in some key areas. MRI Hours is one of the select areas. For the past few years the Province has offered funding to some hospitals on an annual basis to expand capacity of service. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond the base volumes. Given that KGH has been selected to provide additional volumes, our definition of this performance indicator is base volumes plus WTS Incremental cases plus any additional in-year SE LHIN volume adjustments.

Target: Baseline 08/09: 4627 hrs, Target 09/10: 4700 hrs, Target 10/11: 4700 hrs, Target 11/12: 5035 hrs.

Indicator: OR Cases (Inpatient and Outpatient))



	Actual	Target
10-Q1	2123	**2098**
10-Q2	2171	**2098**
10-Q3	2175	**2098**
10-Q4	2296	**2098**
11-Q1	2318	**2286**

Interpretation - Patient And Business:

This increased number of cases is a result of increased operative time that has been responsive to patient care needs as well as addressing incremental PCOP funded volumes... In general patients are receiving more timely care and better access to surgical services. Business Perspective: The increase in case volume has been achieved within budget subsidized with PCOP funding.

Actions & Monitoring Underway to Improve Performance:

OR case activity is monitored on a daily, weekly, and monthly basis by the OR management and the Surgical Preoperative Anesthesia (SPA) Program. Quarter to Quarter variations in OR volumes are common and are influenced by many variables (e.g. number of cancellations, holidays, and surgeon availability). Volumes are closely monitored and it is anticipated these will balance by year end.

Definition: Described as the total number of inpatient and outpatient cases in the operating room (OR).

Target: Baseline 08/09: 8488, Target 09/10: 8390, Target 10/11: 8390, Target 11/12: 8390

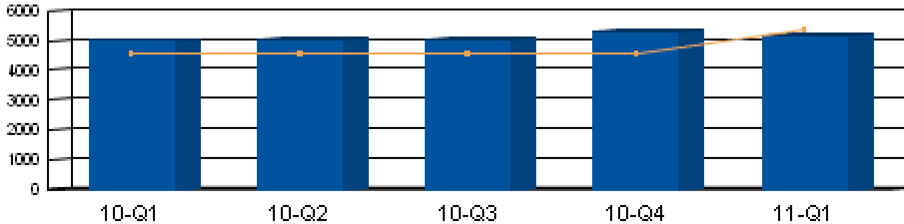
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
10-Q1	5007	**4537**
10-Q2	5050	**4537**
10-Q3	5042	**4537**
10-Q4	5279	**4537**
11-Q1	5191	**5345**

Interpretation - Patient and Business:

The addition of extra operative hours in the evening hours during the week coupled with a higher number of rooms available in the summer has created additional operative time. This is a positive trend as the OR hours increase and additional cases can be completed in a more timely manner.

Actions & Monitoring Underway to Improve Performance:

Quarter to Quarter variations are common and are influenced by many variables (e.g. number of cancellations, holidays, and surgeon availability). OR hours are closely monitored and it is anticipated these will balance by year end.

Definition: Operating room (OR) hours is described as the total inpatient and outpatient operating room hours staffed and available in the operating room.

Target: Baseline 08/09: 21143, Target 09/10: 18148, Target 10/11: 18148, Target 11/12: 18148

Indicator: Percent of Wait Time Contracted Volumes Achieved

	Actual	Target
11-Q1	36	**100**

Interpretation - Patient And Business:

Only 4 of 11 volume contracts are on target (2 of 4 general surgical categories, scoliosis repair, and CT hours). Areas of greatest concern at this time are total joint replacements and cholecystetomy. Every effort is being made to maximize Hotel Dieu Hospital capacity in these two areas. Because these are only Q1 results, we anticipate improvements throughQ2 and Q3 that would put us back on target. Not achieving these targets by year end poses the risk of these volumes being adjusted downward and permanently reassigned to neighbouring hospitals. This carries a financial risk to the organization.

Actions & Monitoring Underway to Improve Performance:

The Wait Time Committee and the Surgical Program are closely monitoring this area of concern. A realignment of OR time scheduled across the 7 day week for the fall of 2011 will help with optimizing OR utilization and therefore case throughput.

Definition: In order to strategically increase service in select clinical services, the Province has provided incremental funds to support expanded volumes. As hospitals already have funding for a base level of services, the additional incremental funding must be earned by expanding services beyond these base volumes. Given that KGH has been selected to provide additional volumes in many different areas, our definition of this performance indicator is dividing the number of incremental volume contracts on target by the total number of contracts expressed as a percent. It is intended to provide an overall view of progress with respect to meeting MOH volume contracts.

Target: Target 11/12: 100%

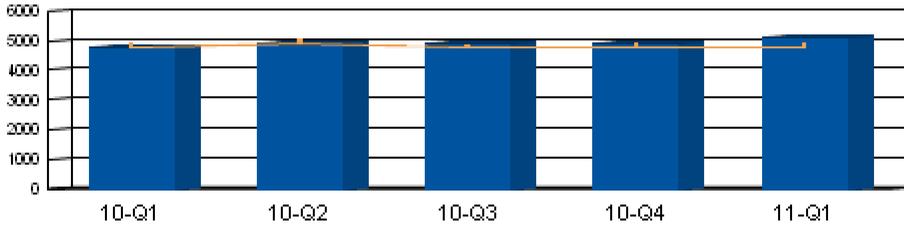
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Total Inpatient Admissions



	Actual	Target
10-Q1	4741	**4782**
10-Q2	4912	**4919**
10-Q3	4878	**4779**
10-Q4	4925	**4782**
11-Q1	5082	**4782**

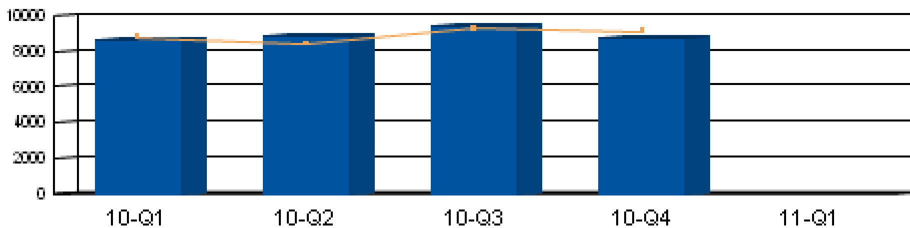
Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Total number of admissions to inpatient wards is a measure of total inpatient activity in the hospital.

Target: Baseline 08/09: 19464, Target 09/10: 19400, Target 10/11: 19400, Target 11/12: 19400

Indicator: Total Inpatient Weighted Cases



	Actual	Target
10-Q1	8626	**8787**
10-Q2	8877	**8411**
10-Q3	9369	**9284**
10-Q4	8710	**9103**
11-Q1		

Interpretation - Patient And Business:

Patient Perspective: Weighted case volumes for Q4 are within planned levels which has a positive benefit to both maintaining the level and mix of services (primary, secondary, tertiary) provided to the population of South Eastern Ontario.

Business Perspective: Achieving the desired volume of targeted weighted cases could ultimately have a positive financial impact on the hospital. Q4 total weighted case results are below target but well within the 10% corridor of performance.

Definition: Total Inpatient Weighted Cases is a measure of total inpatient output of the hospital. By converting cases to a normalized measure using case Resource Intensity Weights (RIW) a common overall measure of output is produced.

RIW methodology is a relative resource allocation tool for estimating a hospital's inpatient-specific resource consumption. RIWs are used to standardize the expression of hospital case resource consumption, recognizing that not all patients require the same health care resources. Total resource consumption is then expressed as "weighted cases".

Target: Baseline 08/09: 35291, Target 09/10: 35300, Target 10/11: 35300, Target 11/12: 34616

Kingston General Hospital

Strategy milestone 14

KGH clinical staff adopt evidence-based guidelines in 6 clinical areas

Strategic direction	KGH 2015 outcome	Fiscal 2012 initiative
Increase our focus on complex-acute and specialty care	Best evidence used to guide practice	Increase adoption of clinical practice guidelines
Indicator(s)		**Status**
Number of Clinical Areas That Have Implemented Open Source Order Sets		Green

1. **What are the contributing factors?**

   This is a new initiative just underway. An order set is a group comprehensive, best practice/evidence-based practitioner orders that assist providers in managing common healthcare issues and interventions/procedures in a variety of patient populations. The benefits to patient safety and quality of care are expected by using best practice/evidence based templates to ensure appropriate treatments, medications, and investigations. The Critical Care program was the first to have adopted order sets into patient care.

2. **Are we on track to meet the milestone?**

   Yes. 6 patient care areas are targeted for year end and the rollout is on schedule.

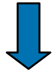
3. **Actions planned/underway**

   The Order Set Steering Committee is actively working on a plan that will schedules expansion of order sets in other programs/areas through out the year.

Kingston General Hospital

Milestone #14

				10-Q4	11-Q1
SD4 Increase our focus on complex-acute and specialty care	KGH clinical staff adopts evidence-based guidelines in 6 clinical		Number of Clinical Areas that have Implemented Open Source (OS)	**N/A**	**G**

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

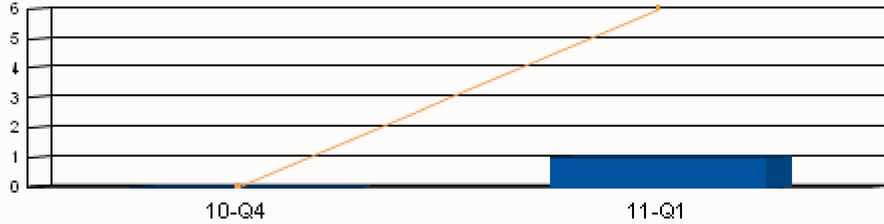
Kingston General Hospital

Milestone #14

SD4 Increase our focus on complex-acute and specialty care

KGH clinical staff adopt evidence-based guidelines in 6 clinical areas

Indicator: Number of Clinical Areas that have Implemented Open Source (OS)



	Actual	Target
10-Q4	0	
11-Q1	1	**6**

Interpretation - Patient and Business:

An order set is a group of comprehensive, best practice/evidence-based practitioner orders that assist healthcare providers to manage common healthcare issues and interventions/procedures in a variety of patient populations. The benefits to patient safety and quality of care are expected by using best practice/evidence based templates to ensure appropriate treatments, medications and investigations. Reduced length of stay and readmission rates are also expected to be supported with use of Order Sets.

Actions & Monitoring Underway to Improve Performance:

Implementation has just begun with implementation in the Critical care program. Promotion and development is through the Order Set Committee.

Definition: Clinical Areas - generally defined as the programs. However, SPA and Medicine are too large. These programs will be divided by service areas. Several areas fall outside of the program structure and these will be defined by group e.g. Allied Health, Diagnostic Imaging

Adoption – order set development and approval by MAC

Target: Target 11/12: 6

Strategy milestone 15

Average sick days per KGH employee are reduced to 10.5

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	KGH Is designated as one of the best places to work	Launch our staff scheduling system
Indicator(s)		**Status**
Launch a Staff Scheduling Project		Green
Average sick days per eligible employee per year		Yellow

1. **What are the contributing factors?**

   Scheduling: There has been considerable lag time with respect to hiring a project manager. A decision was made at the Operations Committee that a budget would only be allocated to hire a full-time in-house project manager in the IMIT department to support this initiative.

   Sick time: Overtime is the lowest in 3 years. ONA had the most significant improvements with a 40% lower rating compared to June 2010. Greater emphasis.

2. **Are we on track to meet the milestone?**

   Yes.

   Scheduling: Work is underway; we anticipate being on track by year end.

   Sick time: We are on track to achieve the 10.5 average sick days for this year.

3. **Actions planned/underway**

   Scheduling: IMIT has been asked for a contingency plan, if a qualified candidate is not hired by mid-August. Such a plan could include contracting with an external firm to provide the service. However, this will have to go back to the Operations Committee for approval.

   Sick time: Collective bargaining enables changes to HOODIP plan for CUPE/ONA and changes to vacation booking for ONA.

Kingston General Hospital

Milestone #15

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
E1 People	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee per Year	Y	Y	Y	Y	Y	↑
			Launch the Staff Scheduling Project					G	
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↑
			Percent Sick Time Hours	Y	Y	G	G	Y	↑
			Total Full Time Equivalents (FTEs)	Y	G	Y	Y	G	↑

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

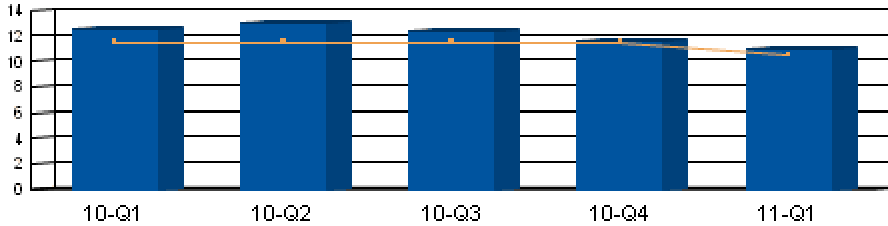
KGH Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Average Sick Days per Eligible Employee per Year



	Actual	Target
10-Q1	12.5	**11.5**
10-Q2	13.1	**11.5**
10-Q3	12.4	**11.5**
10-Q4	11.6	**11.5**
11-Q1	10.9	**10.5**

Interpretation - Patient and Business:

There has been continued progress toward our goal with the average for the calendar month of June posting at 10.90, surpassing the previous fiscal year goal of 11.5, and down each month from the previous month. This number has broken the "11 barrier" and most significantly is the lowest since current tracking methodology started in 1999.

The ONA group now sits at 14.13 with a median number of absence days equal to 9.0. From the human resource records this translates into approximately 32,000 hours per year from the beginning of the PIP. The month of June stand alone statistics for ONA was 40% lower than June of last year.

The CUPE staff monthly statistics for June were up, similar to the increase demonstrated in June 2010; however the rolling average for CUPE at 12.49 is still an improvement. The average number of hours is trending downward for all groups, which is reflected in the statistics.

The top 5 reasons for absence continue to be the same although the percentage fluctuates as follows: musculoskeletal 23%, psychological 19%, infectious Illness 18%, surgery 17%, and pregnancy related 5%.

Actions & Monitoring Underway to Improve Performance:

Significant developments for ONA and OPSEU central negotiations through arbitration awards that included a provision under the HOODIP plan to withhold payment for the 6th and subsequent incidence of sick time for the first fifteen hours. This cost item enabled cost neutrality for the collective agreements over two years; specifically at KGH, it is anticipated savings to be approximately $126,000 per year (based on last year's usage). Provincially, it was calculated by the OHA that the average number of incidents was six for ONA (KGH is only at 3.13). The 6th incident coincides with our attendance program entry, which may be an additional incentive for staff to be off work less often.

Vacation is seen to be an issue to allow staff to take vacation, allow junior members to have some summer vacation, and ensure staff actually takes their vacation. Vacation can be linked to wellness, job satisfaction, injury prevention and sick time. Issues surrounding vacation were tabled and discussed at all local negotiations (CUPE, ONA, OPSEU). Outcomes of those discussions are still pending.

Another 'poster' printing with the absence goal posted and departmental listings is planned for the end of quarter. Numerous stage 3 meetings of our attendance program continue; however, there are some pending ones which will become more challenging to schedule during peak vacation time in July and August. The Attending Practitioner's Statement (APS) is being adapted for pregnancy related sick time to address issues around modified work and the current higher trend of this type of sick time.

Promotion of the daycare partnership which includes emergency day care to begin in July; with a scheduled opening this fall. Information booths on-site and it will be included in KGH This Week and KGH Today articles.

Definition: The average sick days per eligible employee tracks all sick time of an employee on a twelve month rolling basis. Employees included are all active employees, eligible for paid sick time, as at the last day of the last calendar month of the twelve month period. Active employees include employees on leave of absence. It does not include employees who have terminated, retired or transferred to part-time positions during the twelve month period reported. The average is calculated based on total sick hours for all employees eligible for paid sick time divided by the total number of active employees, eligible for paid sick time as at the last day of the month. A day is based on 7.50 hours. The corporate goal is to reduce the average sick time to the Human Resources Benchmarking Network (HRBN) average for the healthcare sector in Ontario.

Target: Baseline 08/09: 14.03, Target 09/10: 12, Target 10/11: 11.5, Target 11/12: 10.5

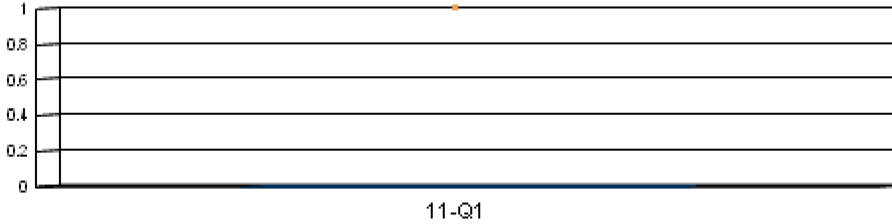
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Launch the Staff Scheduling Project



	Actual	Target
11-Q1	0	**1**

Interpretation - Patient and Business:

Considerable lag time to hire a project manager. Decision was made at Operations that budget was only to be allocated to hire a full-time inhouse PM and that the position report into Information Management. IMIT has been asked for contingency plan if they are unable to hire by mid August; i.e. PM from a contracted company. However, based upon the decision at Operations, this will have to be sent back to Operations for approval to allocate the required funding for an external PM.

Actions & Monitoring Underway to Improve Performance:

Information Management via the CIO, has been asked for a contingency plan of an external PM source.

Definition: The purpose of the scheduling project is to increase efficiencies through standard processes, centralized scheduling and deployment of updated technologies to create capacity for frontline managers and staff. The improvement of staff scheduling against union contracts across the hospital will decrease sick time and overtime payments. This project will leverage the current workforce scheduling software that has already been procured at the hospital to gain these efficiencies. The measurement is that the project will be in its configuration stage by March 2011.

Target: Target 11/12: Yes

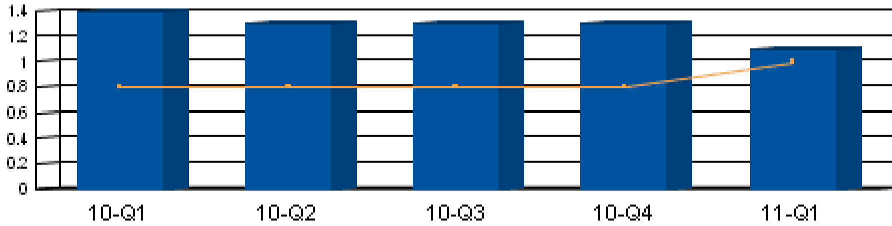
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Percent of Overtime Hours



	Actual	Target
10-Q1	1.4	**0.8**
10-Q2	1.3	**0.8**
10-Q3	1.3	**0.8**
10-Q4	1.3	**0.8**
11-Q1	1.1	**0.99**

Interpretation - Patient and Business:

Overtime levels were lower than any time in the previous 3 years. The hot spot areas remain Emergency, Medicine, Pediatrics and Critical Care. Maintenance and the Resource pool were also in a variance for overtime to date. Many of the higher areas of overtime also tend to have higher sick time.

The impact of changes including bed map changes and/or moves, creation of a different make up of units to better align work within the services has demonstrated a link to overtime.

Actions & Monitoring Underway to Improve Performance:

Sick time issues have reduced particularly for the ONA (nurses) group which may account for some of the reduction in overtime. Challenges with movement of units and workload resulted in staff movement and reassignments. The hospital and union (ONA) are working together on workload complaints which have yielded some preliminary results such as an increase in staffing baseline compliment on one of the floors. Other movement with the onboarding of mental health created movement and ripples with several staff posting into jobs, then returning to their previous jobs within a very short period.

Scheduling remains an opportunity for potential improvements which could reduce overtime as a potential outcome. There will be a scheduling project undertaken in this fiscal year to assist the organization in improving in this area, and discussions are underway regarding a task group with our nursing union to look at scheduling challenges and solutions jointly. Local bargaining addressed some isolated issues in a positive direction and mutual understandings were gained.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator that covers full-time staff. This indicator measures the percentage of overtime hours worked by all employees (i.e. not including purchased services) compared to the total hours worked.

Target: Baseline 08/09: 1.9%, Target 09/10: 0.8%, Target 10/11: 0.8%, Target 11/12 0.99%

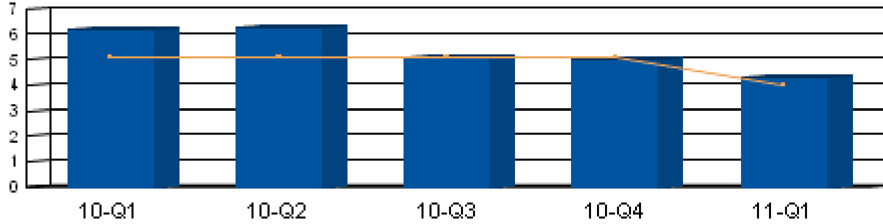
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Percent Sick Time Hours



	Actual	Target
10-Q1	6.2	**5.1**
10-Q2	6.3	**5.1**
10-Q3	5.1	**5.1**
10-Q4	5.0	**5.1**
11-Q1	4.3	**4.0**

Interpretation - Patient and Business:

Sick time hours target has reduced from 5.1 to 4.0 which is a significant drop from the previous three years. Sick time is reducing considerably with the lowest levels for KGH in at least ten years.

The ONA group has made the most significant gains on sick time which impacts on other facets since they are most likely to be replaced if they are off work. From the human resource records this translates into approximately 32,000 hours per year from the beginning of the PIP. The month of June stand alone statistics for ONA was 40% lower than June of last year.

A greater emphasis on vacation for all groups has been beneficial, even for CUPE, which continued to have higher June statistics than desired, however, still trending downward and still an improvement.

The top 5 reasons for absence continue to be the same although the percentage fluctuates as follows: musculoskeletal 23%, psychological 19%, infectious Illness 18%, surgery 17%, and pregnancy related 5%.

Actions & Monitoring Underway to Improve Performance:

Significant developments for ONA and OPSEU central negotiations through arbitration awards that included a provision under the HOODIP plan to withhold payment for the 6th and subsequent incidence of sick time for the first fifteen hours. This cost item enabled cost neutrality for the collective agreements over two years; specifically at KGH, it is anticipated savings to be approximately $126,000 per year (based on last year’s usage). Provincially, it was calculated by the OHA that the average number of incidents was six for ONA (KGH is only at 3.13). The 6th incident coincides with our attendance program entry, which may be an additional incentive for staff to be off work less often.

Vacation is seen to be an issue to allow staff to take vacation, allow junior members to have some summer vacation, and ensure staff actually takes their vacation. Vacation can be linked to wellness, job satisfaction, injury prevention and sick time. Issues surrounding vacation were tabled and discussed at all local negotiations (CUPE, ONA, OPSEU). Outcomes of those discussions are still pending.

Numerous stage 3 meetings of our attendance program continue; however, there are some pending ones which will become more challenging to schedule during peak vacation time in July and August. The Attending Practitioner’s Statement (APS) is being adapted for pregnancy related sick time to address issues around modified work and the current higher trend of this type of sick time.

Promotion of the daycare partnership which includes emergency day care to begin in July; with a scheduled opening this Fall. Information booths on-site and it will be included in KGH This Week and KGH Today articles.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator that measures the percentage of sick time provided by full-time employees. Full-time employees are defined as those employment statuses that are full-time, part time temporary full-time or job sharing, and casual temporary full time. Occupational groups include Management & Operational Support (M&OS), Unit Producing Personnel (UPP), and Nurse Practitioner (NP).

Target: Baseline 08/09: 6.6%, Target 09/10: 5.2%, Target 10/11: 5.1%, Target 11/12 4.0%

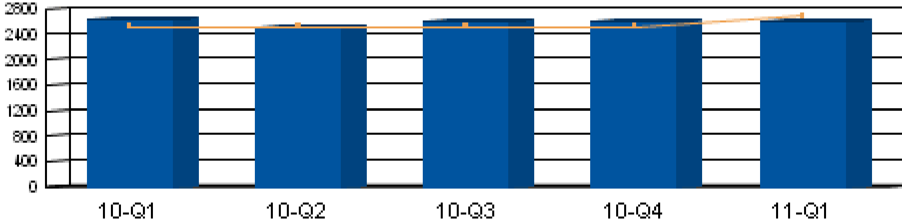
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Total Full Time Equivalents (FTE's)



	Actual	Target
10-Q1	2624	**2515**
10-Q2	2511	**2515**
10-Q3	2618	**2515**
10-Q4	2601	**2515**
11-Q1	2613	**2687**

Interpretation - Patient and Business:

The transfer of Mental Health Services (mid - June) will result in an increase in FTEs in future quarters. With the continued reduction in sick time, the impact to FTEs will be a reduction for those areas where sick time is replaced.

Actions & Monitoring Underway to Improve Performance:

Continue strategies to reduce sick time to 10.5 days target.

Definition: This is a Hospital Annual Planning Submission (HAPS) indicator. This indicator measures the average number of unit producing and management operational & support full-time equivalents (FTEs) in the facility in a given period. FTEs are calculated by total earned hours divided by FTE hours (1950 hours). FTE counts provide a common denominator in which to measure total hours e.g. KGH could have 4000 employees but they equate to only 3200 FTEs while another hospital may have only 3700 employees but their total FTEs equals 3100 employees.

Target: Baseline 08/09: 2648, Target 09/10: 2566, Target 10/11: 2515, Target 11/12: 2579

Kingston General Hospital

Strategy milestone 16

Lost time injury claims are reduced by 10%

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	All preventable harm to staff is eliminated	Improve workplace safety
Indicator(s)		**Status**
Reduction of lost time injuries		Red

1. **What are the contributing factors ?**

   Lost time injury claims are the highest they have been in the last three quarters (six incidents). Three caused by falls; three caused by MSI. The amount of time off was mitigated through the provision of modified duties. Overall MSI injuries are green with an upward trend.

2. **Are we on track to meet the milestone?**

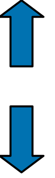
   As of Q1, we are at risk of not achieving this milestone. With focused effort we could be on track to meet the milestone. There is concern by managers about the Percent Completion of Incident Investigations which is trending off target.

3. **Actions planned/underway**

   The Management Inspection Program is scheduled to be rolled out in Fall 2011. The program focuses on ensuring hazardous conditions and behaviours are recognized and controlled ; enforcing revised Safe Footwear Policies; MSI: focus group on safe patient handling to identify barriers to use of mobility tools; any equipment needs, (i.e. shortage of transfer boards and sleeves); and implementation of manager's monthly inspections via training and policy. An awareness campaign for needlestick injury has been completed. The phlebotomy project to centralize blood collection with ECT Technologists is underway.

Kingston General Hospital

Milestone #16

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
E1 People	Lost time injury claims are reduced by 10%		Lost Time to Injury	N/A	N/A	N/A	N/A	R	
			Musculoskeletal Injuries (MSIs)	R	G	G	R	G	
			Percent Completion of Incident Investigations	R	R	R	R	R	
			Reduction in Needle Stick Injuries	N/A	N/A	N/A	N/A	R	
			Reduction in Time Lost Due to Musculoskeletal Injuries	N/A	N/A	N/A	N/A	R	

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

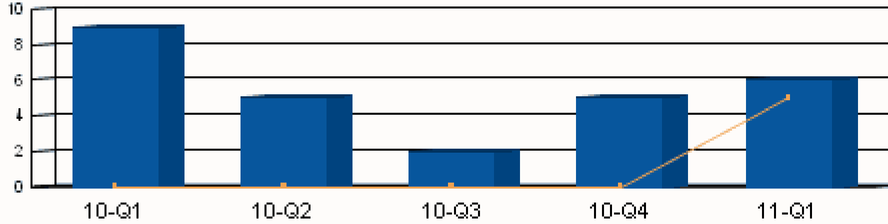
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Lost Time to Injury



	Actual	Target
10-Q1	9	
10-Q2	5	
10-Q3	2	
10-Q4	5	
11-Q1	6	**5**

Interpretation - Patient and Business:

This incidence of LTI's is higher than our last 3 quarters. 3 LTIs in April, 1 in May and 2 in June.
Three (3) were caused by falls and 3 were musculoskeletal in nature.
2 of the 6 LTI's occurred in SPA program.
Although these injuries were significant, the amount of lost time was limited through the provision of modified duties. It is important to note that the consequences of these injuries have not yet resolved in all cases. Footwear was a contributing factor in 2 recent falls- one which resulted in lost time (worker wearing flip flops and fell down stairs) and the other which was a critical injury (fracture) where the worker was wearing platform shoes and slipped on wet floor.
Five (5) additional LTI claims were denied in this quarter.

Actions & Monitoring Underway to Improve Performance:

The optimal way to reduce LTI's is through prevention of the injuries in the first place. Despite the most effective claims management, when significant injuries occur, workers may be unable to return to regular and/or modified duties right away. Our management inspection program which is being rolled out in the Fall, is a key part of our strategy to reduce staff injuries by ensuring hazardous conditions and behaviours are recognized and controlled before injuries happen. Knowing that skips/trip/falls are a common cause of injury in healthcare, and have recently resulted in some significant injuries, as an organization we should be enforcing our Safe Footwear Policy. Currently there are many staff (including management) who do not adhere to the policy.

Definition: Workplace injuries that result in a worker being unable to report to work, even in a modified capacity, are a measure of the severity of injury incurred. Hospitals are benchmarked against one another by the WSIB according to lost time injury (LTI) frequencies. LTI frequency and severity (total days per claim) are the key metrics used for selecting organizations to participate in health & safety improvement initiatives such as workwell audits and targeted intervention by the Ministry of Labour (MOL). It is LTI's that result in the majority of our WSIB claim costs. Reducing LTI's means substantial savings on the NEER statement and the potential for year end rebates rather than surcharges.

Target: Target 11/12: 19 (10% reduction from fiscal 10/11)

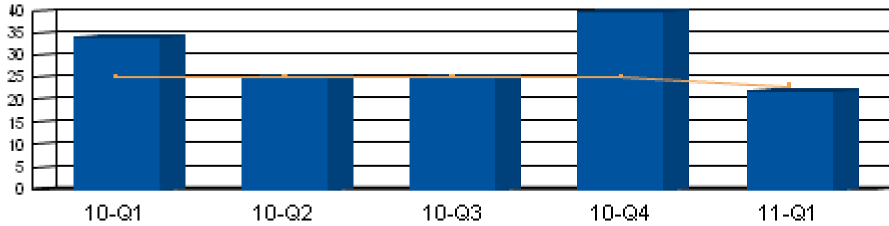
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Musculoskeletal Injuries (MSIs)



	Actual	Target
10-Q1	34	**25**
10-Q2	25	**25**
10-Q3	25	**25**
10-Q4	40	**25**
11-Q1	22	**23**

Interpretation - Patient and Business:

Of the 22 MSI's reported, 13 (60%) occurred in patient care areas and of these, 5 were related to patient handling. Of the patient handling MSI's, 1 was related to the Titan lift not working.

With increased awareness it is possible that staff is reporting minor aches/pains/symptoms that they otherwise wouldn't have reported in the past however this is the lowest reported incidence over the past year.

Actions & Monitoring Underway to Improve Performance:

In order to address our MSI incidence, the following is being undertaken: 1- focus group on safe patient handling to evaluate the MSI prevention program that was put in place in 2010, identify barriers to use of mobility assessment tool, and any equipment needs (i.e. shortage of transfer boards & sleeves), 2- implementation of monthly management inspection program- this program will assist in identifying unsafe work conditions and/or behaviours and provide opportunity for manager to address prior to injury. 3- Manager/Supervisor Hazard Recognition and Control training which is planned for the fall 2011 will address the hazards common to healthcare and strategies to control them. As well this training will again address the importance and ways in which investigations of incidents should be undertaken to ensure we are identifying and addressing the actual underlying causes of the incidents. Investigation of incidents is a key opportunity to address hazards. Currently there is little being done in the way of implementation of corrections or improvements as a result of workplace injury.

Definition: MSI rate is a measure of health & safety performance and linked to Ministry of Labour (MOL) involvement and Workplace Safety & Insurance Board (WSIB) costs. The MSI measure is divided into 1-MSI’s related to patient handling and 2- MSI’s other. MSI’s are tracked monthly. Based on the premise that workplace injuries are preventable, they are unacceptable and our long term goal should be “zero” MSIs. MSIs are the type of injury that most often result in delayed recovery & permanent limitations.

Target: Baseline Fiscal 08/09: 150, Target 09/10: 100, Target 10/11: 100, Target 11/12: 90

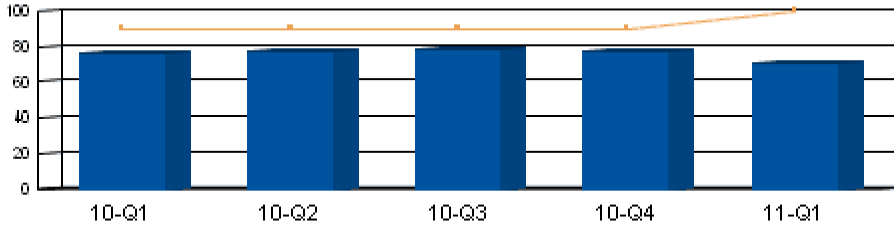
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Percent Completion of Incident Investigations



	Actual	Target
10-Q1	76	**90**
10-Q2	77	**90**
10-Q3	78	**90**
10-Q4	77	**90**
11-Q1	70	**100**

Interpretation - Patient and Business:

Overall average for the 3 months was 70%. There has been little change on this metric despite the fact that the identification & timely resolution of workplace hazards is a fundamental responsibility of a 'supervisor' and a key strategy in preventing the recurrence of injuries to our staff. Current process-managers/supervisors are 'tasked' within Safe Reporting requesting they investigate the reported incident and they receive a reminder if still incomplete 2 to 4 weeks later. While the investigations may eventually get done, they are not always initiated in a timely manner in conjunction with the affected employee, and corrective actions selected in Safe Reporting suggest that the immediate causes rather than root causes are the focus. It is critical that we understand and control the true, underlying cause(s) otherwise we will see little improvement in our incidence of workplace injury.

Actions & Monitoring Underway to Improve Performance:

Manager/Supervisor "Hazard Recognition & Control" training is planned for the fall and will incorporate incident investigations. Training will include Root Cause Analysis as a means of analyzing the underlying causes of an incident/injury and will speak to the types of corrective actions/improvements that would effectively control the cause(s) (i.e. process improvements/changes, communication to staff, workplace re-design, equipment changes, progressive discipline, etc). OH&S is also putting a new process in place whereby a reminder within the Safe Reporting Tool will be sent on day 4 (policy requires they be done within 3 business days) to those who have not yet completed. Along with this reminder, templates to assist the Manager/Supervisor are attached as is an offer of assistance form OHS. to further support compliance, incident investigation completion rates have become part of the Director's quarterly reports and is part of Executive rounds.

Definition: Investigating workplace incidents ensures due diligence in terms of identifying and resolving hazards that contribute to injuries. This is a legislative requirement under the Occupational Health & Safety Act (OH&S Act) and demonstrates our commitment as an organization in managing hazards and creating a work environment that is safe for staff and patients. Collecting & analyzing the underlying causes and putting in place correction actions/improvements is a key strategy in the elimination of all preventable harm. Calculation is based on the percentage of investigations completed as compared to those that were required. The goal for 2011 is for 100% of employee/affiliate general safety events submitted in Safe Reporting to be investigated by managers/supervisors.

Target: Baseline Fiscal 08/09: Between 20-30% of investigations are completed, Target Fiscal 09/10: 90% completion, Target Fiscal 10/11: 90% completion, Target 11/12: 100% completion

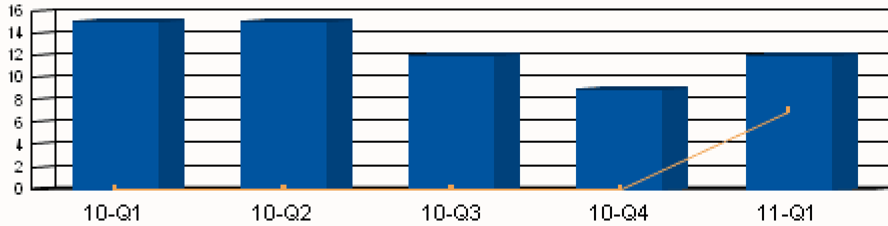
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Reduction in Needle Stick Injuries



	Actual	Target
10-Q1	15	
10-Q2	15	
10-Q3	12	
10-Q4	9	
11-Q1	12	**7**

Interpretation - Patient and Business:

Locations of NSIs were as follows: 1 critical care, 3 Emergency, 5 in medicine, and 3 in SPA. Two(2) of the needlesticks were in Enviro staff, 3 occurred in Medical Resident, and a staff member in Connell 10 sustained 2 NSI's during this quarter. At least 4 were caused by a delay in or improper activation of the safety mechanism on the needle, the 2 Enviro incidents were due to improper disposal of needles in the garbage, and 1 was due to disposal of the sharp into a sharps container that was already full. One NSI involved the Safe Lok butterfly which, although safety engineered, is a first generation product and not easily activated.

Actions & Monitoring Underway to Improve Performance:

Incident investigation by management is the best way to address the root causes of these needlestick injuries. In most cases it is not a failure of the device but a behaviour that leads to injury. While there is a plan to submit a business case for conversion to a newer butterfly that is easier to activate and is associated with a reduction in NSI's, reducing NSI's needs to focus on increased staff awareness and reinforcing safe practices during use of sharps.

Definition: Needlestick injuries are one of the indicators used to measure the success of KGH's sharps management program. The incidence is also used by the Ministry of Labour to determine whether the hospital is putting in place adequate controls to protect workers from the risk of blood-borne pathogens. Each year thousands of health care workers sustain needlestick injuries in Canada; each one of these injuries carries the risk of exposure to serious and even potentially fatal infections with bloodborne pathogens such as HBV, HCV or HIV. Analysis of needlestick injruy data, investigation of all needlestick injuries, and implementation of corrective measures/improvements will result in safer use of medical sharps and a reduced risk of serious occupational disease claims.

Target: Target 11/12: 26

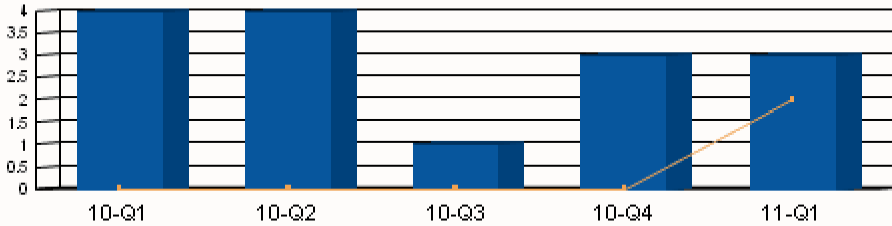
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Reduction in Time Lost Due to Musculoskeletal Injuries



	Actual	Target
10-Q1	4	
10-Q2	4	
10-Q3	1	
10-Q4	3	
11-Q1	3	**2**

Interpretation - Patient and Business:

The 3 MSI's that resulted in lost time occurred in Imaging, Nutrition, and in the Oncology Program (Resource Pool PCA). One was directly related to patient handling, one involved the failure in equipment, and the third resulted in the employee lifting too much from a cart.

Actions & Monitoring Underway to Improve Performance:

While the majority of staff has been trained on MSI prevention, we continue to see a high incidence of MSI's. The management workplace inspection program will provide managers/supervisors with the opportunity to observe employees identify possible hazards/unsafe practices and reinforce safety expectations and correct hazards before injuries occur.   As well, the expectation that these inspections be shared with staff will hopefully heighten overall awareness of safety.

Where injuries do happen, identifying and correcting the cause(s) is a perfect opportunity to prevent recurrence. It is important that injuries and the resulting improvements be shared by managers with their staff.

Failure to investigate in a timely manner and control the actual underlying cause(s) is a missed opportunity. Incident investigation will be part of the Management training this fall on Hazard Recognition & Control.

Definition: Musculoskeletal Injuries (MSIs), as a main cause of lost time injuries, result in the highest workplace injury costs. MSIs often result in delayed recovery, long periods of modified/alternate work, permanent accommodation, or an inability to return to employment at the hospital. Reduction in MSI's that result in lost time will reduce the hospital's injury costs and avoid the negative repercussions to the employee & their unit/dept that are associated with a reduced ability to function in the workplace.

Target: Target 11/12: 10.8

Kingston General Hospital

Strategy milestone 17

100% of our staff complete mandatory online training

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
People	Staff are engaged in all aspects of our quality, safety and service improvement initiatives	Enhance our leadership and learning programs
Indicator(s)		**Status**
Percent of Staff that Complete Mandatory Online Training Programs		Red

1. **What are the contributing factors?**
   The Learning Management System (LMS) is not totally operational and not hard wired into the KGH systems. The final definition of mandatory has been expanded to include: Workplace Conduct, Patient-Family Centred Care, Privacy.

2. **Are we on track to meet the milestone?**
   Anticipate that milestone will be met at year-end. Improvement over month of July/August with the following statistics: Accessibility – 79%; MSI 96%; Workplace Violence 85% and WHIMIS at 86%.

3. **Actions planned/underway**
   The LMS is being upgraded mid August with a redesign over the next two months. An assessment of the process for employees methodology to complete mandatory education is underway. Planning is ongoing for staff and manager onboarding sites.

Kingston General Hospital

Milestone #17

				10-Q4	11-Q1
E1 People	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	R

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

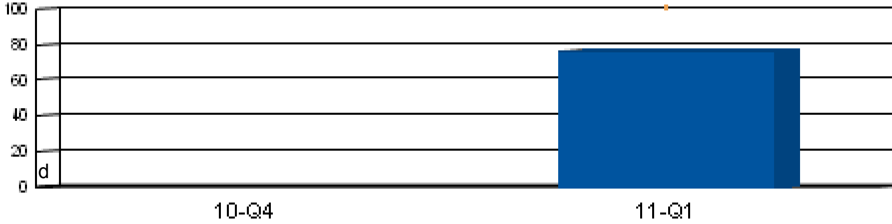
Kingston General Hospital

Milestone #17

E1 People

100% of our staff complete mandatory online training

Indicator: Percent of Staff that Complete Mandatory Online Training Programs



	Actual	Target
10-Q4		
11-Q1	76	**100**

Interpretation - Patient and Business:

Overall mandatory training compliance rate is at approximately 76%; the definition of mandatory training expanded to include Workplace Conduct, Patient-Family Centered Care and Privacy but not yet included in compliance rates; manager on-boarding module not yet developed.

Actions & Monitoring Underway to Improve Performance:

MSI was at 92%; however, of great concern is the completion rate for Workplace Violence training. For Q1 it was at 71% and has not changed significantly, even though the August 2nd has past. There has been numerous follow-up to managers and directors; will now EMC direct follow-up.

Definition: Currently, mandatory training includes Incident Reporting, Accessibility, WHIMS and Musculoskeletal Injury reporting. The Learning Management System (LMS) is being upgraded and enhanced to allow all staff access to mandatory training on-line. Functionality is such that managers can obtain timely reports on the status of compliance for each employee. This will increase the opportunities for following up and ensuring supports are put in place to permit employees to complete required training. Further training I enhancements will be put into place (e.g., on-line General Orientation, on-line On Boarding modules, tracking of refresher requirements) to ensure on-going mandatory training and re-training occurs at times convenient to the employee.

Target: Target 11/12: 100%

Kingston General Hospital

Strategy milestone 18

100% of our KGH managers complete mandatory process improvement training

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Processes	Continuous improvement environment created with consistent use of LEAN principles	Increase LEAN process adoption
Indicator(s)		**Status**
Percent of Management Staff that Complete Mandatory Process Improvement Training		Yellow

1. **What are the contributing factors?**
   There have been discussions but no agreement regarding most effective modality and linking to action by the leader. Timeline for delivery is winter . The milestone will be met by year-end.

2. **Are we on track to meet the milestone?**
   Yes, the milestone will be met by March 2012.

3. **Actions planned/underway**
   Meetings scheduled to discuss further. Integration with Leadership Development program.

Kingston General Hospital

Milestone #18

				11-Q1
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

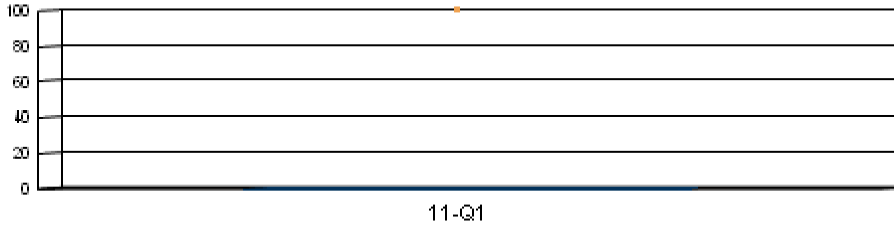
Kingston General Hospital

Milestone #18

E2 Processes

100% of KGH managers complete mandatory process improvment training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
11-Q1	0	**100**

Interpretation - Patient and Business:

There have been discussions on most effective modality and linking it to action. The delivery of this is not planned until early 2011. So it will remain as yellow for the next two quarters.

Actions & Monitoring Underway to Improve Performance:

Meeting scheduled between People Services and Process Excellence at the end of August to discuss recommendations regarding modality.

Definition: Introduction of lean principles to the KGH Leadership Group will enable a focus on long-term sustainability with a comprehensive approach to change. It will drive operational efficiency and cultural change at the same time. It provides tools for the managers to use and a consistent approach on how we expect the organization to be run. The measurement will be a percentage of our KGH Leadership Group (non-physician) who attends the training.

Target: Target 11/12: 100 %

Strategy milestone 19

96% of our Phase 1 redevelopment is completed on time, on budget and new retail and nutrition facilities are in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Facilities	Phase 1 redevelopment is complete, Phase 2 construction is underway and KGH has sufficient parking	Complete Phase 1 redevelopment and establish new retail and food service facilities

Indicator (s)	Status
Phase 1 Redevelopment is Completed on Time and on Budget	Green
Redevelopment (Space for New Clinical, Retail, Nutrition Facilities)	Green
Phase 2 Redevelopment Planning Grant Achieved	Green

1. **What are the contributing factors?**

   Lobby, Retail and Nutrition delayed. Plan under-estimated Ministry approvals required. Phase 1, 96 % completed, but Post Contract Contingency (PCC) still not resolved.

   Phase 2, approval for Stage 2 (verbal); awaiting written approval.

2. **Are we on track to meet the milestone?**

   Yes. New time line December/January 2012 still with March 31, 2012 deadline.

   Phase 1 time line ahead of schedule; budget – dependent of PCC discussions with Ministry.

   Phase 2 progressing into Stage 2 of process, but will not hear about planning grant until after Stage 2 (in 2012/13)

3. **Actions planned/underway**

   Phase 1, meetings on PCC ongoing with Infrastructure Ontario and Capital Branch.

   Phase 2, consultants being hired; RFP planning begun.

   (Please note that more details will be provided to the Resources Committee via individual briefing notes)

Kingston General Hospital

Milestone #19

				10-Q4	11-Q1
E3 Facilities	96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place		Phase 1 Redevelopment is Completed on Time and On Budget	**N/A**	**G**
			Phase 2 Redevelopment Planning Grant Achieved	**N/A**	**G**
			Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)	**N/A**	**G**

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

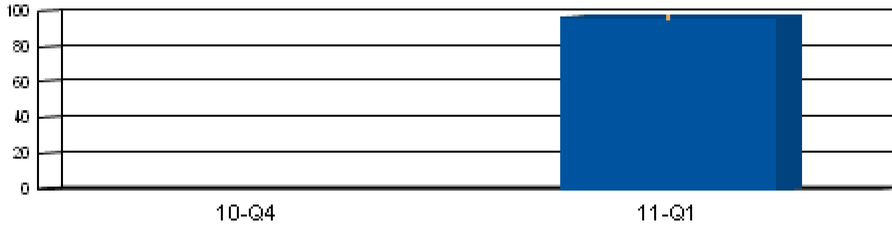
Kingston General Hospital

Milestone #19

E3 Facilities

96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place

Indicator: Phase 1 Redevelopment is Completed on Time and On Budget



	Actual	Target
10-Q4		
11-Q1	96	**96**

Interpretation - Patient and Business:

The project is on time and on budget expected to be completed by 2012 March.

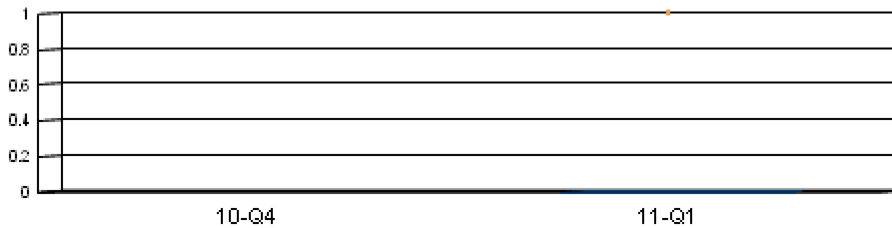
Actions & Monitoring Underway to Improve Performance:

The project team will continue to monitor the project.

Definition: Project completed by 2012 March within the budget of $196M.

Target: Target 11/12: 96%

Indicator: Phase 2 Redevelopment Planning Grant Achieved



	Actual	Target
10-Q4		
11-Q1	0	**1**

Interpretation - Patient and Business:

The MOHLTC has granted approval to go to Stage 1. The MOHLTC no longer provides planning grants in Ontario. The Hospital is responsible for funding the planning work.

Actions & Monitoring Underway to Improve Performance:

Work has begun on the Stage 1 submission to the MOHLTC.

Definition: MOHLTC responded to precapital submission for Phase 2 Redevelopment and granted approval for preparation of Stage 1 proposal.

Target: Target 11/12: Yes

Kingston General Hospital

Milestone #19

E3 Facilities

96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place

Indicator: Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)

	Actual	Target
10-Q4		
11-Q1	0	1

Interpretation - Patient and Business:

The Final Estimate of Cost will be sent to the MOHLTC by 2011 August 08. Once the MOHLTC approves the Stage 4.2 submission the contract will be awarded to the contractor.

Actions & Monitoring Underway to Improve Performance:

It is expected that the contract will be awarded by the end of 2011 August.

Definition: Phase I Redevelopment remains on schedule with substantial completion to be achieved by January 2012.

Retail project has completed the tender process waiting for approval from MOHLTC. Nutrition Facilities tender will close on July 28/11.

Target: Target 11/12: Yes

Kingston General Hospital

Strategy milestone 20

Our new solar farm is established and 50% of carpets are removed from inpatient areas

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Facilities	**KGH is clean, green and carpet-free**	**'Green' KGH by conserving energy and removing carpets from inpatient areas**

Indicator (s)	Status
Percent of Square Footage of Carpet Removal Complete	**Green**
Solar Farm Established	**Yellow**

1. **What are the contributing factors?**

   The "green" status for carpet removal is in large part due to the coordinated effort of all staff and leadership. Solar farm status is "yellow" as we await the approval for our application to the Ontario Power Authority and depending on timing, the decision may be before or after the election (rate of solar energy reimbursement is an election issue).

2. **Are we on track to meet the milestone?**

   Yes. The carpet removal project is proceeding as quickly as possible, with 28% (32,800 sq. ft.) to be removed by Sept 2011. The remaining Phase 1 113,600 sq. ft. to be removed by Dec. 2012. Currently awaiting MOH announcement for Phase 2 removal (130,000 sq. ft.) to be completed by Dec. 2013. The solar farm project is likely delayed until 2012/13 due to the Ontario Power Authority approval process.

3. **Actions planned/underway**

   Kidd 7 will start carpet removal in Sept. 2011.

   We continue to work with the Ontario Power Authority to advance approval of the solar project.

Kingston General Hospital

Milestone #20

				10-Q4	11-Q1
E3 Facilities	Our new solar farm is established and 50% of carpets are removed from inpatient areas		Percent of Square Footage of Carpet Removal Complete	**N/A**	**G**
			Solar Farm Established		**Y**

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

Milestone #20

E3 Facilities

Our new solar farm is established and 50% of carpets are removed from inpatient areas

Indicator: Percent of Square Footage of Carpet Removal Complete

	Actual	Target
10-Q4		
11-Q1	12.6	**50**

Interpretation - Patient and Business:

Carpet replacement will be completed in 2 phases. Phase 1 A equals 14%, Phase 1 B equals 37% and Phase 2 equals 49% of total $7M project.

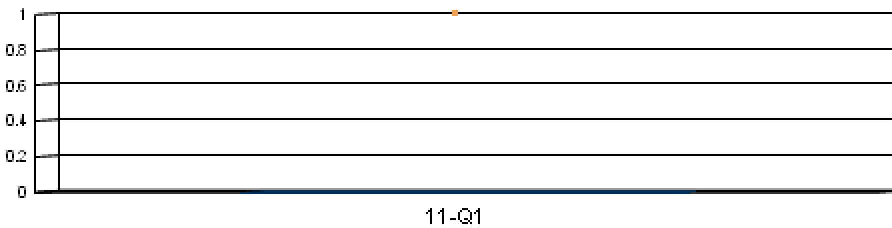
Actions & Monitoring Underway to Improve Performance:

It is anticipated that by 2012 March 31 we will meet the target of 50% complete. Currently the project is moving ahead on schedule.

Definition: Phase 1 A equals 14% Phase 1 B equals 37% and Phase 2 equals 49% of total $7M project.

Target: Target 11/12: 50%

Indicator: Solar Farm Established



	Actual	Target
11-Q1	0	**1**

Interpretation - Patient and Business:

Continue to work with Honeywell to develop a viable business plan.

Actions & Monitoring Underway to Improve Performance:

Continue to work with Honeywell to develop a viable business plan.

Definition: A 110 kW solar farm is proposed for the roof of Burr Wing. 468 solar panels will be connected to the City of Kingston utility grid and will generate guaranteed revenue of $86,841 for 20 years through a contract with the Ontario Power Authority. Before installing the solar panels, the application must be approved by the Ontario Power Authority. Current processing times are estimated at 7 months. The KGH application is not expected to be approved until fall 2011 following which detailed engineering and installation to be complete by the end of 2012. Measurement of completion of this outcome will be based on the % completion of the project.

Target: Target 11/12: Yes

Kingston General Hospital

Strategy milestone 21

50% of our automated medication dispensing system is in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	Rapid transmission of information improves care and operational efficiency	Enable automated medication dispensing
Indicator (s)		**Status**
Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital		Green

1. **What are the contributing factors?**

   We are in the process of completing the selection of a vendor and expect this will be completed in August. The new procurement rules introduced have added some work.

   The carpet removal and renovations set the time line for how fast medication rooms can be augmented as it is the most cost effective time to change the patient floors/med rooms.

2. **Are we on track to meet the milestone?**

   Yes. Achieving this milestone is tied very closely to the timing of planned renovations.

3. **Actions planned/underway**

   RFP decisions pending.

   Clinical Directors are planning medication rooms as carpet plans are done.

Kingston General Hospital

Milestone #21

				11-Q1
E4 Technology	50% of our automated medication dispensing system in place		Automated Medication Dispensing System in Place throughout Inpatient Units within the Hospital	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

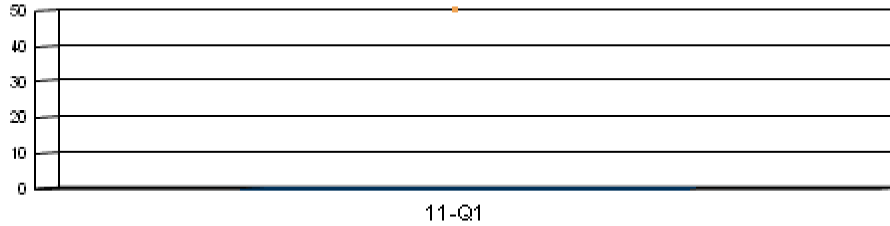
Kingston General Hospital

Milestone #21

E4 Technology

50% of our automated medication dispensing system is in place

Indicator: Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital



	Actual	Target
11-Q1	0	**50**

Interpretation - Patient and Business:

RPF posted, 5 vendors responded, 3SO co-ordinating review of proposals with group including IT, Nursing and Pharmacy. Meeting will occur in mid-August to determine top two vendors who will then be invited to present their proposal

Definition: Automated dispensing cabinets improve patient safety, workflow efficiency, cost analysis and offer secure storage of medications. Indicator is % of locations stocked with medications with cabinets installed.

Target: Target 11/12: 50%

Strategy milestone 22

Our lab and diagnostic imaging order management systems are in place

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	Rapid transmission of information improves care and operational efficiency	Introduce lab and diagnostic imaging order management systems
Indicator (s)		**Status**
Implementation of an Order Management System for Labs on All Inpatient Areas		Green

1. **What are the contributing factors?**

   Work load across the hospital has made clinical engagement difficult, however, a phased approach to Lab order management has resulted in Oncology, ICU and Cardiac Care to participate in this initial phase of implementation.

   Project management resources are also limited. Therefore, the Director, IT manager and clinical leads have provided significant guidance to keep the project moving.

2. **Are we on track to meet the milestone?**

   Yes, however, it must be pointed out that a phased approach has been adopted. Labs is slated for this year and DI for next year. For labs this year, the approach will be to introduce it over six months instead of all at once in September 2011 as originally planned.

3. **Actions planned/underway**

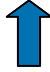
   We are trialing the order management process in a few areas in August 2011.

   KGH/HDH are also considering implementing the approach for HDH lab service.

Kingston General Hospital

Milestone #22

				11-Q1
E4 Technology	Our lab and diagnostic imaging order management systems in place		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	G

Indicates improving performance to target over the past 5 quarters 

Indicates worsening performance to target over the past 5 quarters

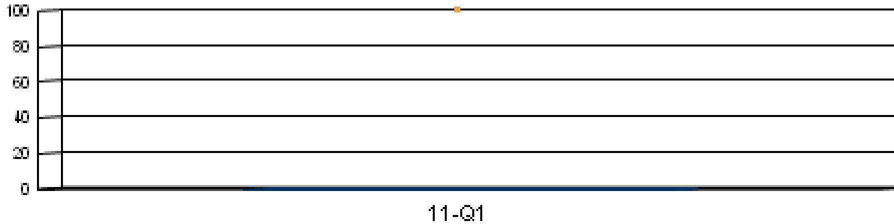
Kingston General Hospital

Milestone #22

E4 Technology

Our lab and diagnostic imaging order managment systems are in place

Indicator: Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).



	Actual	Target
11-Q1	0	**100**

Interpretation - Patient and Business:

Project slowly moving forward, (no project manager assigned to project). LIS required changes have been made and tested. Working closely with 2 floors to trial and then roll out. Floors identified as the Cancer Centre and D4ICU. Planning for the next unit or floor in terms of roll out is underway.

Definition: The goal of the electronic order entry project is to reduce patient risk involved with specimen collection and assist us in meeting Ontario Lab Accreditation standards. The project will introduce efficiencies in clerical time by reducing data entry in the diagnostic areas, while improving our capacity to deliver result more quickly to clinical staff. Existing technologies are being leveraged in order to achieve our goal.

The indicator we will be calculating to measure our success in transitioning to the new system is the percentage of tests that are ordered electronically on the unit over the total number of tests ordered.

Target: Target 11/12: 100%

Kingston General Hospital

Strategy milestone 23

Timely e-discharge summaries are completed for every patient

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Technology	Rapid transmission of information improves care and operational efficiency	Implement electronic discharge for every patient
Indicator (s)		**Status**
Percent of Discharge Communication Sent to Continuing Care Provider Within 72hrs of Patient Discharge		Yellow

1. **What are the contributing factors?**

   Physician uptake on the new E-discharge process is gradual.

   Chart completion is the key issue and although the technology has been fully implemented, we still feel the goal of 80% within 72 hours is achievable by year end. E-discharge is the most effective way of reaching the 72 hour target. A new policy on chart deficiency has been approved and as a result, deficiencies are down 10% at end of Q1 compared to Q4 2011.

2. **Are we on track to meet the milestone?**

   Yes.

3. **Actions planned/underway**

   The E-discharge project has been completed . We are currently working on medication reconciliation with trials scheduled for October 2011. Physician education in e-discharge is ongoing.

Kingston General Hospital

Milestone #23

				10-Q4	11-Q1
E4 Technology	Timely E-Discharge summaries are completed for every patient		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

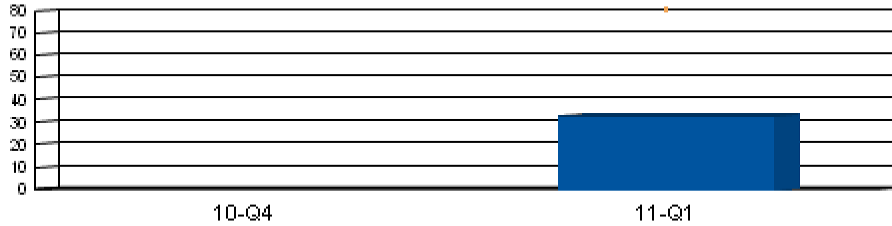
Kingston General Hospital

Milestone #23

E4 Technology

Timely E-Discharge summaries are completed for every patient

Indicator: Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge



	Actual	Target
10-Q4		
11-Q1	33	**80**

Interpretation - Patient and Business:

The indicator percentage is based on first quarter data however this baseline activity is prior to the approval and implementation of the Privilege Sanctions for Incomplete Charts policy supporting the 72 hours completion requirements. Policy approvals allowing Health Information Services to implement operational changes occurred at MAC on June 14th with Operations Committee approval June 23rd. Over the next few months, new processes and system changes by Health Information Services will improved notification to physicians of incomplete charts, monitoring of compliance and corrective actions to achieve target levels.

Definition: The percentage is based on the total number of discharges for the quarter versus the number of discharge summaries available for distribution to the Family Physicians within 72 hours from discharge. NB. Normal newborn and deliveries do not require discharge summaries so these numbers have been excluded from the calculation.

Target: QIP Target 11/12: 80%

Kingston General Hospital

Strategy milestone 24

Our operating deficit is eliminated and our capital spend reaches $12 million

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Finances	Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures	Eliminate our operating deficit and build our capital investment capacity
Indicator (s)		**Status**
Total Dollars for Capital Equipment		Yellow
Total Margin		Green

1. **What are the contributing factors?**

   The capital budget was originally set at $10 million and has recently grown to $10.6 million as we refine the budget and get actual results/funding. Budget at end of first quarter is $1.5 million positive variance for the Hospital overall.

2. **Are we on track to meet the milestone?**

   Yes. It is too early to be certain about increasing capital dollars, but we are still aiming for the $12 million goal for the year. New funding allocations and operating savings will be the source of additional capital dollars. Budget expectations remain positive.

3. **Actions planned/underway**

   Capital allocation will be the focus at each quarter to find more dollars. Quarterly reporting similarly will continue to monitor budget.

KGH Kingston General Hospital

Milestone #24

			10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million	Current Ratio	G	G	G	G	G
		Hospital Operations Actual vs. Plan Variance ($000's)	G	G	G	G	G
		Total Dollars for Capital Equipment	N/A	N/A	N/A	Y	Y
		Total Margin	G	G	G	G	G
		Working Capital	G	G	G	G	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

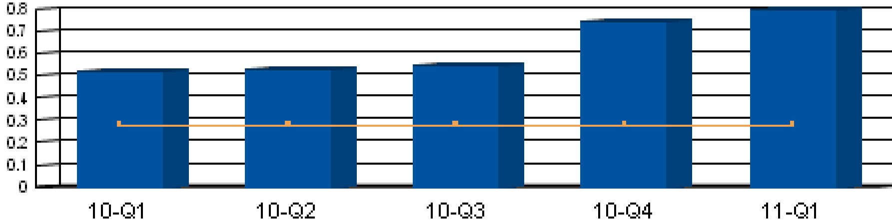
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Current Ratio



	Actual	Target
10-Q1	0.52	**0.28**
10-Q2	0.53	**0.28**
10-Q3	0.55	**0.28**
10-Q4	0.74	**0.28**
11-Q1	0.80	**0.28**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

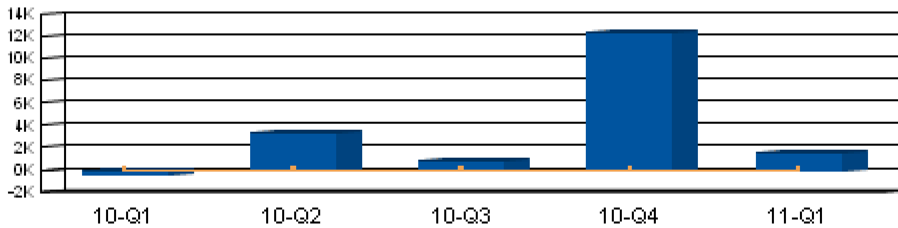
Actions & Monitoring Underway to Improve Performance:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: This is a measure of liquidity indicating the facility's ability to meet short-term obligations. It is calculated by dividing Current Assets by Current Liabilities and comparing to 1. A measure of less than 1.0 means that the hospital is at risk of not being able to meet its current commitments and has limited opportunity to invest in the future (for further information see Working Capital Template).

Target: Baseline 08/09: 0.54, Target 09/10: 0.46, Target 10/11: 0.28, Target 11/12 0.28

Indicator: Hospital Operations Actual vs. Plan Variance ($000's)



	Actual	Target
10-Q1	-496	0
10-Q2	3358	0
10-Q3	868	0
10-Q4	12265	0
11-Q1	1528	0

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Actions & Monitoring Underway to Improve Performance:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: The Hospital operations variance is a comparison of the operating fund surplus or deficit versus planned. It is calculated by subtracting net actual operating expenses [excludes net facility capital] compared to plan. It measures the degree to which the hospital is able to plan, monitor, and live within its financial resources.

Target: Baseline 08/09: 9892, Target 09/10: 0, Target 10/11: 0, Target 11/12: 0

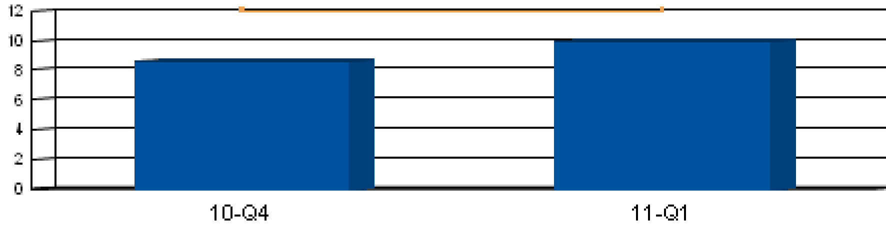
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Total Dollars for Capital Equipment



	Actual	Target
10-Q4	8.568	**12**
11-Q1	10	**12**

Interpretation - Patient and Business:

The total dollars available for capital investment will support the replacement of clinical, non-clinical and information management technology.

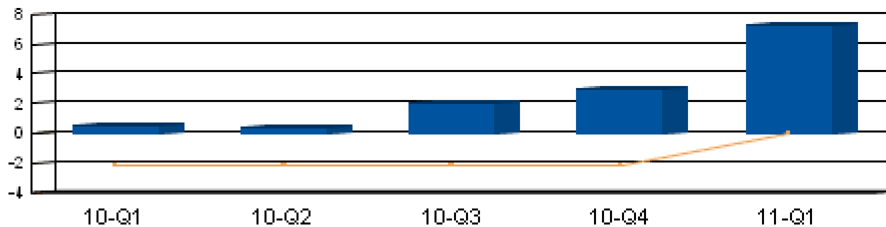
Actions & Monitoring Underway to Improve Performance:

The hospital currently has the capacity to provide $10M in capital investment in fiscal 2012. The organization is continuing to implement the identified operational efficiency initiatives. Additional savings resulting from these activities will be directed towards reaching the $12M target.

Definition: Total amount available for capital investment. Calculated as net equipment amortization less long-term loan payments.

Target: Target 11/12: 12M

Indicator: Total Margin



	Actual	Target
10-Q1	0.54	**-2.17**
10-Q2	0.47	**-2.17**
10-Q3	2.08	**-2.17**
10-Q4	2.95	**-2.17**
11-Q1	7.32	

Interpretation - Patient and Business:

Total margin is a measure of hospital efficiency and the management's ability to live within available financial resources while providing healthcare services as required. A total margin equal or greater than zero indicates that the hospitals operating costs are within the revenue provided from provincial governments and external sources.

Actions & Monitoring Underway to Improve Performance:

The Q1 total margin exceeds the fiscal 2012 target at this point in time. The favourable variance of $1.5M includes higher than planned revenue recoveries and favourable variances to budget as PCOP funded activity (i.e. ICU, surgical) was not operational. Other favourable expense variances should be interpreted as timing differences due to budget phasing at this early stage in the fiscal year.

Definition: Total margin "measures total operating revenues in excess of total expenses". It is a measure of management's efficiency and the hospital's ability to live within available financial resources. Calculated as: Operating Surplus/(Deficit) divided by Operating Revenue. To ensure consistency in calculation between hospitals, the Province has provided a specific definition based on the Hospitals MIS Chart of Accounts. It is inclusive of all fund types (fund 1, 2, and 3), but excludes facility amortization).

Target: Baseline 08/09: (3.9%), Target 09/10: (4.0), Target 10/11: (2.17), Target 11/12: 0

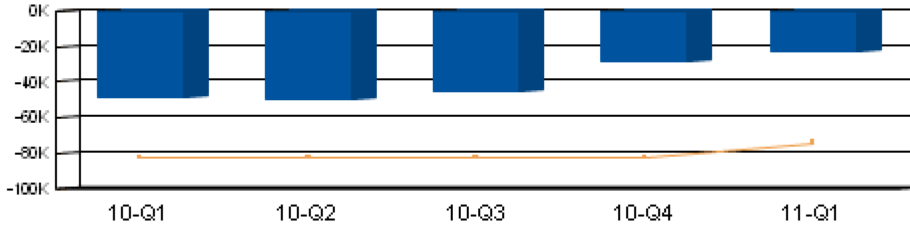
Kingston General Hospital

Milestone #24

E5 Finances

Our operating deficit is eliminated and our capital spend reaches $12 million

Indicator: Working Capital



	Actual	Target
10-Q1	-48225	**-82352**
10-Q2	-49498	**-82352**
10-Q3	-45150	**-82352**
10-Q4	-28451	**-82352**
11-Q1	-22214	**-74000**

Interpretation - Patient and Business:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Actions & Monitoring Underway to Improve Performance:

This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: Working Capital (WC) is the net result of Current Assets (CA) less Current Liabilities (CL). A positive position (CA>CL) indicates funds exist in excess of current obligations, and a negative position (CL<CA) indicates an inability to meet current obligations with current resources. KGH is currently in a negative working capital position and reliant on support from the SE LHIN to ensure ample cash flow to meet current obligations.

Target: Baseline 08/09: (50413), Target 09/10: (76369), Target 10/11: (82000), Target 11/12: (74000)

Strategy milestone 25

Patient, staff and stakeholder engagement takes place through improved website and social media tools

Enabler	KGH 2015 outcome	Fiscal 2012 initiative
Communication	**We continue to engage and report openly and regularly on our progress**	**Improve engagement using modern communication and collaboration tools**
Indicator(s)		**Status**
Implementation of Improved Website and Social Media Tools		**Green**

1. **What are the contributing factors?**
   Communication strategies to support reporting and engagement
   - Internal: KGH This Week, Action Plan for Achieving KGH 2015
   - External: KGH This Year
   - Both: new quarterly reporting format
   - Freedom of Information legislation preparation
   - Department staffing needs addressed

2. **Are we on track to meet the milestone?**
   Yes.

3. **Actions planned/underway**
   - Web and social media strategies underway
   - KGH Connect in development, launching Q2
   - Freedom of Information preparations underway

Kingston General Hospital

Milestone #25

				11-Q1
E6 Communication	Patient, staff, and stakeholder engagement takes		Implementation of Improved Website and Social Media Tools	G

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

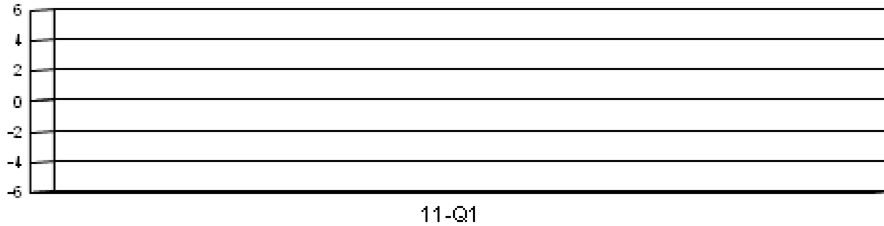
Kingston General Hospital

Milestone #25

E6 Communication

Patient, staff, and stakeholder engagement takes place through improved website and social media tools

Indicator: Implementation of Improved Website and Social Media Tools



	Actual	Target
11-Q1		

Interpretation - Patient and Business:

Plans are underway to launch the KGH “Collaborative,” a new web-based platform to engage regularly with stakeholder, will be launched in Q2.

Actions & Monitoring Underway to Improve Performance:

A comprehensive review of the KGH website has begun. A web strategy in conjunction with IM, will identify areas for improvements. The goal is to find ways in which social media platforms can be used on the website for on-going engagement and interaction with KGH stakeholders.

Definition: Purpose:
KGH will continue to engage and report openly and regularly on our progress: KGH is dedicated to building on the momentum of stakeholder engagement that helped shape KGH 2015. We are committed to communicating with internal and external stakeholders on our progress in ways that exemplify our guiding principles of respect, transparency, engagement, accountability and value for money.

Importance:
We will continue to engage our stakeholders through enhanced communication tools and techniques that will strengthen the KGH brand, instill public confidence in the organization, and help to achieve its aim, outstanding care, always.

Calculation:

- Staff and public engagement metrics
- Brand awareness metrics

Target: Target 11/12: Yes

Kingston General Hospital

Performance Report (KPI)
Quarter 1 Fiscal 2011 - 2012

Strategic Direction	Target	Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD1 Transform the patient experience through a relentless focus on quality, safety and service	Overall patient satisfaction is at or better than the provincial teaching hospital average	Overall Acute Care Patient Satisfaction (%)	G	G	G	N/A	N/A
		Overall Emergency Care Patient Satisfaction (%)	G	G	G	N/A	N/A
		Percent of Patients who Answer "Definitely Yes" to the NRC Picker Question " Would you recommend this Hospital to Your Friends and Family?"	R	R	Y	N/A	N/A
	70% of our people who are surveyed rate us as "Excellent"	Hospital Standardized Mortality Ratio (HSMR)	G	R	G	N/A	N/A
	The number of new cases who acquire infections in our hospital is reduced by 10%	C-difficile	R	R	R	R	R
		Central Line Bloodstream Infections	G	G	G	G	G
		MRSA (Methicillin-resistant Staphylococcus aureus)	Y	R	R	Y	Y
		Number of New Cases of Hospital Acquired Infection	R	G	R	R	G
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y
		Ventilator Associated Pneumonia	R	G	G	G	G
		VRE (Vancomycin-resistant Enterococcus)	G	Y	Y	G	Y
	We achieve 100% hand hygiene compliance across all units and staff	Hand Hygiene Compliance	Y	Y	Y	G	Y
	100% of our clinical services discharge patients at their expected LOS	Average # ALC Patients per Day	G	G	G	G	R
		Overall - Acute Average Length of Stay Days (Based on HSAA)	R	R	Y	Y	Y

Strategic Direction	Goal		Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	Trend
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Overall - Acute Average Length of Stay vs. ELOS (Variance)	Y	G	G	G	G	↑
			Percent ALC Days	R	R	R	R	R	↑
			Percent of Clinical Services Meeting ELOS Target	R	R	R	R	R	↑
			Readmission rate Within 30 Days for Selected CMG's	R	G	N/A	N/A	N/A	↑
	90% of patients receive their elective surgery within or faster than the provincially targeted wait time		All Cancer Surgery Wait time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			All Paediatric Surgery - 90th Percentile Wait Time (Days)	Y	R	R	R	R	↑
			Cardiac Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
			Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
			Coronary Angioplasty - 90th Percentile Wait Time (hrs)	G	G	G	G	G	↑
			Diagnostic Imaging - CT – 90th Percentile Wait time (Days)	G	G	G	G	G	↑
			Diagnostic Imaging- MRI – 90th Percentile Wait time (Days)	R	R	R	R	R	↑
			General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	R	R	G	G	G	↓
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	R	R	R	G	G	↓
			Orthopedic Surgery (excluding total hip and knee replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
			Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets				R	R	↑
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	G	G	G	↑

Strategic Direction	Target		Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD1 Transform the patient experience through a relentless focus on quality, safety and service	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	Y	R	R	G
			Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th percentile wait time (hrs)	R	R	R	R	R
			Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R
			Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	R	Y	Y	R	G
			Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	Y	Y	R	R
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	R	Y	Y	Y	G
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Active Clinical Trials	G	G	G	G	G
			Clinical Trials Generating Revenue	G	Y	Y	G	G
			New Clinical Trials	G	G	G	G	G
			Percent Increase of Externally Funded Research Dollars at KGH					N/A
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	Y	G	Y	G	G
			Ambulatory Care Volumes	G	G	G	G	G
			Cardiac - Angiography Volumes	G	G	G	G	G
			Cardiac - Angioplasty Volumes	G	G	Y	G	Y
			Cardiac - Isolated CABG Volumes	G	G	G	G	G
			Chronic Kidney Disease Program- Weighted Units	G	G	G	G	G

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
			Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
			Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑
			Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
			Hip and Knee Replacement Volume (Wait Time Strategy Allocation)	G	Y	G	G	Y	↓
			Kidney Transplants	G	Y	Y	Y	G	↑
			MRI Hours (Wait Time Strategy Allocation)	G	G	G	R	G	↓
			OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑
			OR Hours (Inpatient & Outpatient)	Y	Y	Y	Y	G	↓
			Percent of Wait Time Contracted Volumes Achieved					R	
			Total Inpatient Admissions	G	G	G	G	G	↑
			Total Inpatient Weighted Cases	G	G	G	G	G	↓
E1 People	Lost time injury claims are reduced by 10%		Lost Time to Injury	N/A	N/A	N/A	N/A	R	
			Musculoskeletal Injuries (MSIs)	R	G	G	R	G	↑
			Percent Completion of Incident Investigations	R	R	R	R	R	↓
			Reduction in Needle Stick Injuries	N/A	N/A	N/A	N/A	R	

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
E1 People	Lost time injury claims are reduced by 10%		Reduction in Time Lost Due to Musculoskeletal Injuries	N/A	N/A	N/A	N/A	R	
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↑
			Percent Sick Time Hours	Y	Y	G	G	Y	↑
			Total Full Time Equivalents (FTE's)	Y	G	Y	Y	G	↑
E4 Technology	Timely E-Discharge summaries are completed for every patient		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge				N/A	Y	
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million		Current Ratio	G	G	G	G	G	↑
			Hospital Operations Actual vs. Plan Variance ($000's)	G	G	G	G	G	↑
			Total Dollars for Capital Equipment				Y	Y	↑
			Total Margin	G	G	G	G	G	↑
			Working Capital	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

Quality Improvement Plan (QIP) Quarter 1 Fiscal 2011- 2012

Strategic Direction	Goal	Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	Trend
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into KGH committees	Number of Patient Experience Advisors on Key Planning/Decision Making Forums	R	R	Y	Y	G	↑
	Overall patient satisfaction is at or better than the provincial teaching hospital average	Percent of Patients Responding "Satisfied" to the Food Patient Discharge Survey	R	R	R	N/A	N/A	↓
		Percent of Patients who Answer "Definitely Yes" to the NRC Picker question "Would you Recommend this Hospital to your Friends and Family"? (QIP)	R	R	G	N/A	N/A	↓
	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture	Hospital Standardized Mortality Ratio (HSMR)	G	R	G	N/A	N/A	↑
		Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data			R	N/A	N/A	
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	Y	R	Y	N/A	N/A	↑
	The number of new cases who acquire infections in our hospital is reduced by 10%	Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 patient days	R	R	Y	R	R	↑
		C-difficile (QIP)	R	G	R	R	G	↑
		Environmental Audits	Y	Y	G	G	Y	↓
		Percent of Sepsis Cases Reviewed by Department Head				N/A	N/A	
		Ventilator Associated Pneumonia (QIP)	R	G	G	G	G	↓
	We achieve 100% hand hygiene compliance across all units and staff	Hand Hygiene Compliance (QIP)					Y	
	100% of our clinical services discharge patients at their expected LOS	Average # ALC Patients per Day	G	G	G	G	R	↑
		Percent ALC Days	R	R	R	R	R	↑

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD1 Transform the patient experience through a relentless focus on quality, safety and service	100% of our clinical services discharge patients at their expected LOS		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	R
			Readmission rate Within 30 Days for Selected CMGs	R	G	N/A	N/A	N/A
	The ED wait time for admitted patients is less than 8 hrs for 100% of patients		90th Percentile ED Wait Time (All Admitted Patients)	R	Y	R	R	G
SD2 Bring to life new models of interprofessional	100% of our clinical areas have implemented ICPM		Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012				R	G
E1 People	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee per Year	Y	Y	Y	Y	Y
E4 Technology	Timely E-Discharge summaries are completed for every patient		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge				N/A	Y
E5 Finances	Our operating deficit is eliminated and our capital spend		Total Margin	G	G	G	G	G

Indicates improving performance to target over the past 5 quarters

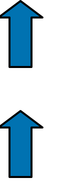
Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

Strategy Scorecard (SSC)
Quarter 1 Fiscal 2011 - 2012

Strategic Direction	Target	Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into KGH committees	Number of Patient Experience Advisors on Key Planning/Decision Making Forums	R	R	Y	Y	G
	Overall patient satisfaction is at or better than the provincial teaching hospital average	Overall Acute Care Patient Satisfaction (%)	G	G	G	N/A	N/A
		Overall Emergency Care Patient Satisfaction (%)	G	G	G	N/A	N/A
	70% of our people who are surveyed rate us as "Excellent" in fostering patient safety culture	Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	G	G	G	N/A	N/A
		Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey				R	R
	The number of new cases who acquire infections in our hosp. reduced by 10%	Number of New Cases of Hospital Acquired Infection	R	G	R	R	G
	We achieve 100% hand hygiene compliance across all units and staff	Hand Hygiene Compliance (SSC)					Y
	100% of our clinical services discharge patients at their expected LOS	Overall - Acute Average Length of Stay vs ELOS (Variance)	Y	G	G	G	G
		Percent ALC Days	R	R	R	R	R
		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	R
	90% of patients receive their elective surgery within or faster than WT target	Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets				R	R
	The ED wait time for admitted patients is less than 8 hrs for 100% of patients	Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R
SD2 Bring to life new models of interprofessional care and education	100% of our clinical areas have implemented ICPM	Implementation of ICPM in All Inpatient Units and Extended to Ambulatory Setting by March 2012				R	G
	The KGH Interprofessional education council	IPE Work Plan Launched				G	G

Strategic Direction	Target		Indicator	10-Q1	10-Q2	10-Q3	10-Q4	11-Q1
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10% and our clinician scientist program expands		Expand Number of Clinician Scientists					G
			Percent Increase of Externally Funded Research Dollars at KGH					N/A
			Research Institute Business and Operating Plan Delivered					N/A
SD4 Increase our focus on complex-acute and specialty care	KGH clinical staff adopt evidence-based guidelines in 6 clinical areas		Number of Clinical Areas that have Implemented Open Source (OS)				N/A	G
	KGH services align with our role as the region's complex-acute and specialty care provider and the Cancer Care at KGH strategic plan is in place		KGH Cancer Care Plan in Place					G
			KGH Participation in Clinical Services Roadmap Initiatives					G
	100% of Target service volumes are met		Percent of Wait Time Contracted Volumes Achieved					R
E1 People	Lost time injury claims are reduced by 10%		Lost Time to Injury	N/A	N/A	N/A	N/A	R
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y
			Launch the Staff Scheduling Project					G
	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs				N/A	R
E2 Processes	100% of KGH managers complete mandatory process training		Percent of Management Staff Completing Mandatory Process Improvement Training					Y
E3 Facilities	Our new solar farm is established and 50% of carpets are removed from inpatient areas		Percent of Square Footage of Carpet Removal Complete				N/A	G
			Solar Farm Established					Y
	96% of our Phase 1 redevelopment is complete on time, on budget, and new retail and nutrition facilities are in place		Phase 1 Redevelopment is Completed on Time and On Budget				N/A	G
			Phase 2 Redevelopment Planning Grant Achieved				N/A	G

				10-Q1	10-Q2	10-Q3	10-Q4	11-Q1	
E3 Facilities	96% of our Phase 1 redevelopment is complete on time, on budget		Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)				N/A	G	
E4 Technology	50% of our automated medication		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital					G	
	Our lab and diagnostic imaging order management		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).					G	
	Timely E-Discharge summaries are completed for every		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge				N/A	Y	
E5 Finances	Our operating deficit is eliminated and our capital spend reaches $12 million		Total Dollars for Capital Equipment				Y	Y	
			Total Margin	G	G	G	G	G	
E6 Communication	Patient, staff, and stakeholder engagement takes place		Implementation of Improved Website and Social Media Tools					G	

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