fiscal 2011-2012 **Q2**

2nd quarter ended Sept. 30, 2011

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

KINGSTON GENERAL HOSPITAL

Table of Contents
KGH Master Performance Report
Q2 Fiscal 2011 - 2012

Strategic Direction 1

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

Table of Contents

Table of Contents

Strategic Direction 3

Cultivate patient oriented research

Strategic Direction 4

Increase our focus on complex-acute and specialty care

Table of Contents

Enabler 1

People

Enabler 2

Processes

Enabler 3

Facilities

Table of Contents

Enabler 4

Technology

Enabler 5

Finances

Enabler 6

Communication

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 is our actual performance on each of the indicators for this milestone as listed above?** The target for year end was to have 15 patient experience advisors integrated and serving as part of KGH Committees. The number was exceeded in Q1 and continues to grow. By end of Q2, we have 26 advisors, 23 of which are sitting on 19 standing committees (For example, Quality of Patient Care, Patient Safety & Quality Committee, Accessibility Committee, Elder Friendly Committee).

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The engagement of advisors and the Patient and Family-Centred focus continues to expand within the organization, as leaders and staff hear and realize the benefit of the patient perspective being factored into planning and decision making. The fact that KGH is being accepted for presentations, now at an international level, and that hospitals and organizations outside of KGH are expressing interest in our approach provides additional validation of the work and encourages our staff/teams and the advisors who are driving changes.

3. **Are we on track to meet the milestone by year end?** The target of having 15 advisors in place has been met and exceeded. It is now anticipated that by fiscal year end we will have at least 40 advisors actively engaged in quality, safety and service improvement initiatives.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** The initiative is being managed to ensure that the presence and value of the advisors is solidly embedded in the hospital operations. This means ensuring that the plan remains comprehensive; processes are well designed, and there is sufficient resource and support for activities. Internal and external presentations will continue with emphasis on the infrastructure, processes and value of partnering with advisors. The role and activities of the advisors will be profiled at the November 2011 community engagement event which is expected to bolster the recruitment of more advisors to support the ever growing number of initiatives.

Kingston General Hospital

Milestone #1

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

Indicates worsening performance to target over the past 5 quarters 

Indicates improving performance to target over the past 5 quarters 

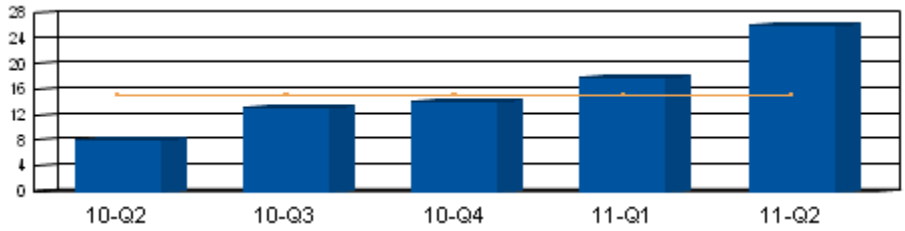
Kingston General Hospital

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-Q2	8	**15**
10-Q3	13	**15**
10-Q4	14	**15**
11-Q1	18	**15**
11-Q2	26	**15**

Interpretation - Patient And Business:

26 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 wherever patient care is discussed. We are actively working at orienting advisors to the Mental Health Program Council. An advisory council has been established for the Regional Cancer District. We are working on including advisors in all hiring interviews. 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 is our actual performance on each of the indicators for this milestone as listed above?** The most recent data for this indicator is Q4 F10/11 in keeping with the near 6 month delay with obtaining reliable numbers and NRC Picker closing off reports. The Overall Acute Inpatient Satisfaction target is the Ontario Teaching Hospital average (93%), and the KGH Q4 performance was 91% which reflects as 3.8% decline from Q3. The Overall Emergency Care Patient Satisfaction target is the Ontario Teaching Hospital average (85%), and at the end of Q4, the KGH Q4 performance was 80% which reflects a 10% decline and is less than the fiscal 2008 baseline of 83.1%.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Patient flow issues are believed to negatively impact the patient experience, and especially those in or moving from the emergency department with delays in admission and discharge process. The NRC Picker results show Medicine & Internal Medicine as the services with decreased satisfaction in measures of access to care; continuity and transition; emotional support. Surges in medicine program activity result in delayed admission and/or placement on units outside of the program.

3. **Are we on track to meet the milestone by year end?** Current trending would indicate that this milestone has risk. Although 3 of 5 supporting indicators are recorded green, 4 of 5 are worsening over the last quarter.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** All programs are engaging patient experience advisors to provide input to processes and improvements. Each program is reviewing their own results and developing action plans to support improvements. Other opportunities include medication reconciliation rollout; initiatives to improve patient flow; new food service; revised patient and visitor guidebook

Kingston General Hospital

Milestone #2

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	R	Y	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	R	G	Y	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)	R	Y	Y	N/A	N/A	↓

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

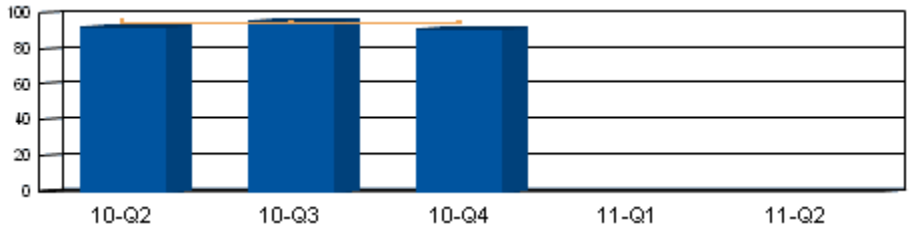
Kingston General Hospital

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-Q2	91.9	**94.6**
10-Q3	94.8	**94**
10-Q4	91	**94**
11-Q1		
11-Q2		

Interpretation - Patient And Business:

In quarter 4, KGH concluded fiscal 2011 with greater than 91% in overall satisfaction for the year. In quarter 1 and 3 we exceeded the Ontario Teaching Hospital Average.

Although the overall quarter 4 fiscal 2011 results show a decrease in the 8 dimensions of care ongoing monitoring and sharing of information with programs and departments continues.

Actions & Monitoring Underway to Improve Performance:

The ICPM has been rolled out to all inpatient units and work continues with sustainability. The delay in moving admitted patients from ER can negatively affect satisfaction as well as some patients feel discharge was before they were ready.

Many initiatives impact the patient satisfaction ratings. These include the Interprofessional Collaborative Practice Model, Patient Flow, Patient and Family Focused Care, increased awareness of the Patient Family Advisory Council, and an increased number of patient experience advisors. Monitoring the NRC+ Picker satisfaction results gives us some indication if the changes are meeting the needs of patients and families. Two units implemented the patient health record outside each patient room for ready access to practitioners. Patient experience advisors are participating in the interview of new employees. Office space is now available for the patient experience advisors.

Medication reconciliation at admission continues with full implementation anticipated for 2012.

Programs are reviewing specific patient satisfaction data within their respective programs and monitoring the impact of changes within their programs over time.

The revised Patient and Family Guide will be trialed in November and December and revised in early 2012 based on patient family feedback.

We will continue to monitor patient satisfaction related to specific focused questions such as quality of food and enviroment.

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

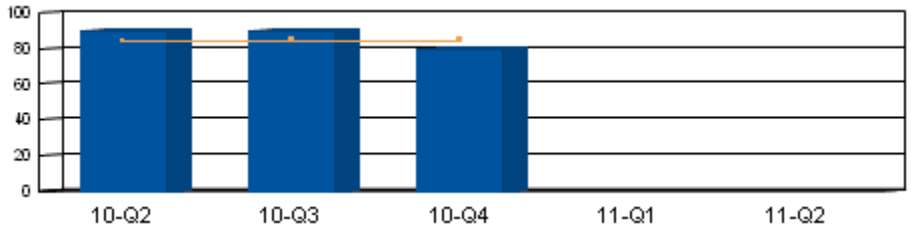
Kingston General Hospital

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-Q2	90.1	83.9
10-Q3	89.6	84.5
10-Q4	79.7	84.5
11-Q1		
11-Q2		

Interpretation - Patient And Business:

Although there is a 4.8% decrease in the overall quality of ED care, ED satisfaction remains above the Ontario Teaching Hospital average in 5 dimensions of care and the same in the dimension of care realted to information and education. Given this slight decrease ongoing montiroting will occur and the target has not been adjusted.

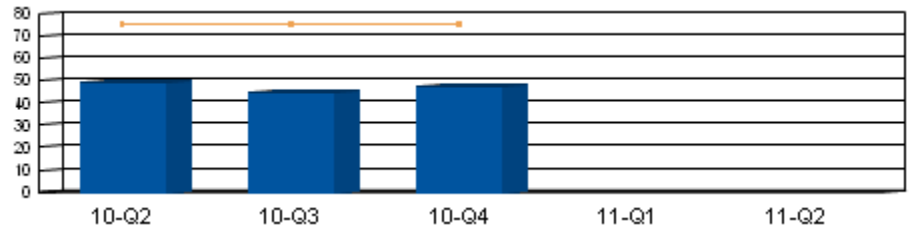
Actions & Monitoring Underway to Improve Performance:

The number of respondents increased to 81 (27%) response rate. This is below the required 100 respondents. The volume of surveys was increased to try and reach the 100 respondent goal but not reflective yet. ICPM will be introduced in March 2012 in the ED. The EDIS tracking system improved monitoring from registration to discharge or transfer. Physician intial assessment time has improved and KGH averages 2hours and 30minutes, the best time in Ontario. The triage process is changing to improve patient assessment and appropriate patient placement within the department. An extra physician was added at peak times and is also available when there are increased volumes or critical surges. In this quarter, we had surges of up to 23 patients in a week compared to the usual 10 – 15 (both in Feb and March).

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.

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



	Actual	Target
10-Q2	49.6	75
10-Q3	44.9	75
10-Q4	47	75
11-Q1		
11-Q2		

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%

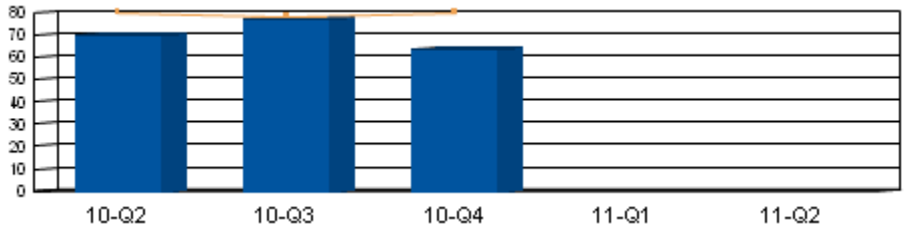
Kingston General Hospital

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?"



	Actual	Target
10-Q2	70	80
10-Q3	77	78.2
10-Q4	64	80
11-Q1		
11-Q2		

Interpretation - Patient And Business:

In this quarter there was a 13% decrease in the number of people who would recommend to family and friends compared to the previous quarter. Ongoing monitoring of this continues at the corporate andprogram level .

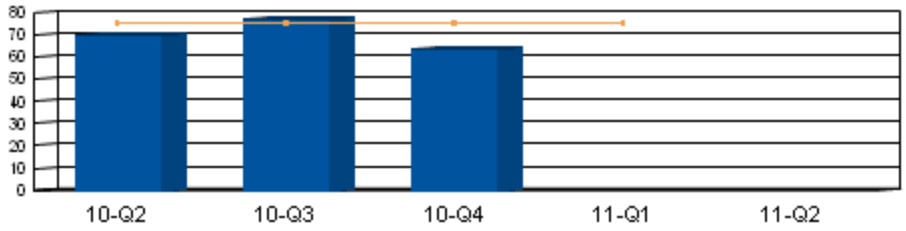
Actions & Monitoring Underway to Improve Performance:

Given this drop in satisfaction monitoring will continue. Individual programs are also monitoring this important question. The impact may also be related to delays in admisson from ED, discharge readiness, and critical care surges. The continued implementation of ICPM in ambulatory settings may improve satisfaction as well as the value and increased awareness of the patient experience advisors influence in contributing to change.

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

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-Q2	70	75
10-Q3	77	75
10-Q4	64	75
11-Q1		75
11-Q2		

Interpretation - Patient And Business:

In this quarter there was a 13% decrease in the number of people who would recommend to family and friends. Ongoing monitoring of this is occurring at the program level .

Actions & Monitoring Underway to Improve Performance:

Given this drop in satisfaction monitoring will continue. Individual programs are also monitoring this important question. The impact may also be related to delays in admisson from ED, discharge readiness, and critical care surges. The continued implementation of ICPM in ambulatory settings may improve satisfaction as well as the value and increased awareness of the patient experience advisors influence in contributing to change.

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

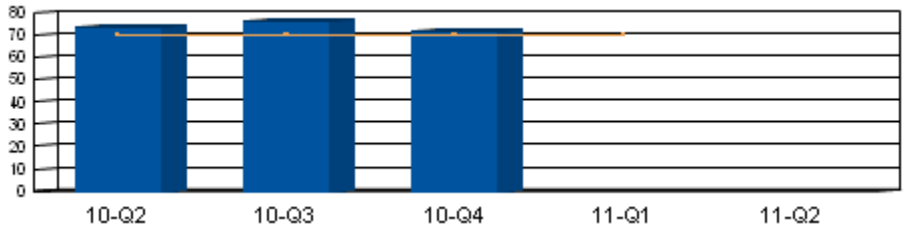
Kingston General Hospital

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



	Actual	Target
10-Q2	73.4	70
10-Q3	76.3	70
10-Q4	72	70
11-Q1		70
11-Q2		

Interpretation - Patient And Business:

The 72% above target and represents the feedback which is received through the NRC + Picker Patient Satisfaction Survey which is conducted on discharge. Construction and winter conditions impact the first impression of KGH.

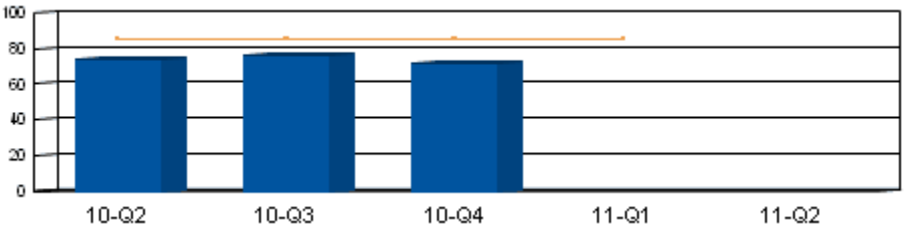
Actions & Monitoring Underway to Improve Performance:

Results of survey continue to be shared with our team with an emphasis on the importance of first impression during the winter months.

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%

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



	Actual	Target
10-Q2	73.4	85
10-Q3	76.3	85
10-Q4	72	85
11-Q1		85
11-Q2		

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

1. **What is our actual performance on each of the indicators for this milestone as listed above?** This indicator has not had new data since Q1. With a less than 20% response rate on the Patient Safety Culture Survey, only 25% of staff rated KGH as very good or excellent against a target of 70%.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Initiatives undertaken before the survey have either not been well communicated or have been less effective in developing the culture than anticipated. Mortality reviews are conducted on a quarterly basis using HSMR data. The status of this indicator is currently red because mortality reviews are not being completed on time.

3. **Are we on track to meet the milestone by year end?** No, and actions are being taken to support improvements by the time of the next survey in March 2012. The safety culture survey results have been reviewed by the Executive and leadership group and a number of actions and initiatives have been decided upon with accountability and timelines. The HSMR, a supporting indicator of a safe patient environment, has reached a target of 100 indicating no unexpected mortality within the organization. This reflects improvement from the baseline value of 111 in fiscal 2008.
Mortality reviews by departments with accountability to MAC began in Q3 fiscal 2010. While completion is done, timeliness to meet reporting deadlines is a concern.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** A heightened focus on safety begins in November with the KGH Patient Safety Week which includes a number of events that profile safety initiative along with the launch of regular Executive sponsored patient safety rounds. The recruitment for Director of Patient Safety and Quality remains in progress, and there has been secondment of support in the short term for project work (Critical Incidents). The VP of medical administration is actively working to improve the timeliness of mortality review submissions.

Kingston General Hospital

Milestone #3

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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)	R	G	G	N/A	N/A	↑
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data		R	R	N/A	N/A	
			Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey			R	R	N/A	

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

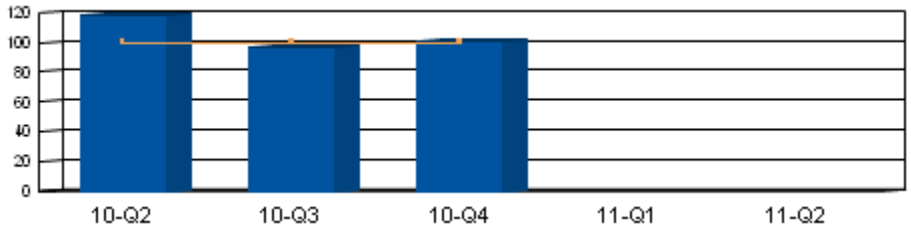
Kingston General Hospital

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-Q2	119	**100**
10-Q3	97	**100**
10-Q4	101	**100**
11-Q1		
11-Q2		

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.

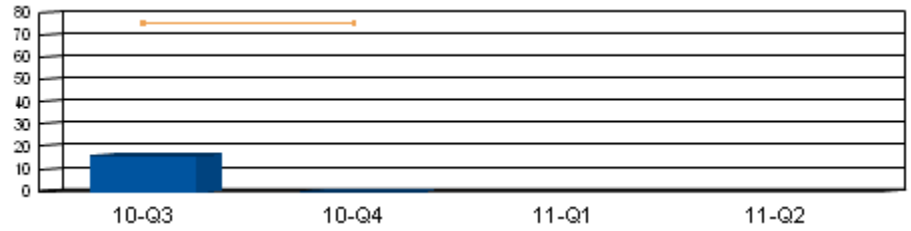
Actions & Monitoring Underway to Improve Performance:

The most recent available data is Q4 fiscal 10/11. The HSMR is 101 and is deemed as not significant by the Canadian Institute for Health Information (CIHI). The fiscal 10/11 annual HSMR was also released and is 102 which is also deemed not significant by CIHI. Quarterly morality reviews are ongoing by the clinical departments. Any concerns or trends are reported to the MAC's 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	0	**75**
11-Q1		
11-Q2		

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%

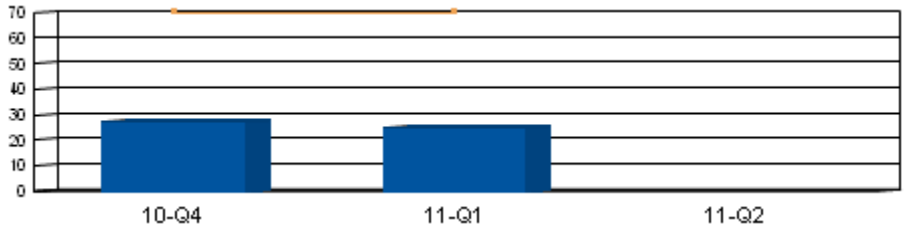
Kingston General Hospital

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**
11-Q2		

Interpretation - Patient And Business:

Note: Q4 10/11 values are based on September 2009 Survey results, Q1 11/12 values are based on May 2011 Survey Results. The next completed survey is scheduled for April 2012.

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 is our actual performance on each of the indicators for this milestone as listed above?

Hand Hygiene compliance has increased 2% from Q1. The current Q2 rate is 85% against a target of 90%. This is a significant increase from the Fiscal 2008 baseline of 44%.

2. What are the contributing factors to the current performance of the indicators for this milestone?

A broad institutional awareness of hand hygiene rates and impact has been in place since Q3 Fiscal 2009. The Handy Audit tool introduction through the CAHO ARTIC project has made data collection and analysis robust. Public reporting, frequent data analysis by all wards and posting on hospital wards and public entrances has maintained visibility on the awareness to meet compliance targets.

3. Are we on track to meet the milestone by year end?

Current compliance data would support that hand hygiene is on track for reaching target by year end.

4. What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?

Continued executive messaging supporting 100% hand hygiene compliance with linkage of messaging at all patient safety walkabouts. Compliance accountability is tied to Infection Control Service and Infection Control Committee. Monthly Handi Audit reports are standing agenda at Infection Control and Patient Safety and Quality Committee meetings.

Kingston General Hospital

Milestone #4

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	G	Y	Y	↓
			Hand Hygiene Compliance (QIP)				Y	Y	
			Hand Hygiene Compliance (SSC)				Y	Y	

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

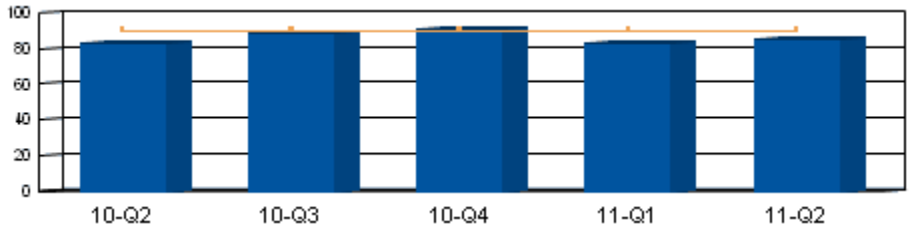
Kingston General Hospital

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-Q2	83	**90**
10-Q3	88	**90**
10-Q4	91	**90**
11-Q1	83.3	**90**
11-Q2	84.7	**90**

Interpretation - Patient And Business:

Patient perspective: Hand hygiene rates remain steady but just below target. However, markers of poor HH such as MRSA infections remain low and so the consequences of HHR below target are not being reflected, for the time being, by a clinically relevant effect.

Business perspective: 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 environtment 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%

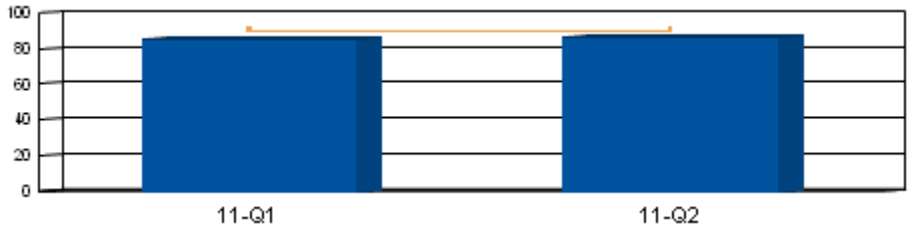
Kingston General Hospital

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**
11-Q2	86.8	**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%

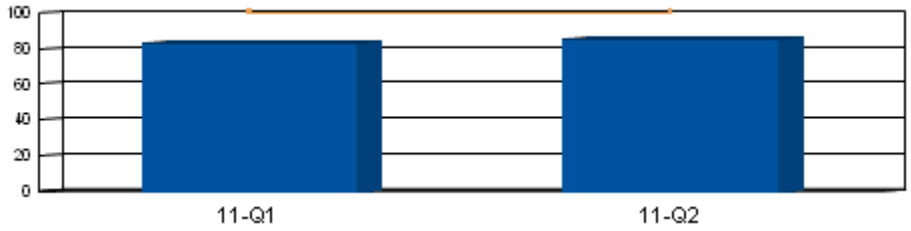
Kingston General Hospital

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**
11-Q2	84.7	**100**

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 environtment 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	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The quarterly target of 31 cases represents a 10% reduction from our average quarterly rate of 35 cases. In Q2, we experienced an increase of 6 cases over Q1 resulted in 36 cases for Q2. This represents a 20% increase in new infections in Q2.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Contributing to this rise in new infections was a C. difficile outbreak declared in August (declared over in mid Q3) and a second quarter rise in central line bloodstream infections. It is important to note that this result was attributable to only two patients with central lines. The infectious disease prevention practices in critical care remain a high priority.

3. **Are we on track to meet the milestone by year end?**
   We are on track to meet this milestone. Nine infection related indicators are embedded into this milestone. While only two are green, five others are trending positively including the rate of C difficile infections, surgical site infection prevention and Vancomycin resistant Enterococcus infections. A two quarter rise in central line infections and a 66% increase in Methicillin resistance Staphylococcus infections in Q2 are of concern.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   A heightened awareness linking nosocomial infection with hand hygiene compliance was a contributor to a short lived C difficile outbreak. Provincial standards for environmental cleaning are frequently monitored. An antibiotic stewardship program is being introduced in Q3.

Kingston General Hospital

Milestone #5

			10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	Y	R	R	Y	↑
		C-difficile	R	R	R	R	R	↑
		C-difficile (QIP)	G	R	R	G	R	↑
		Central Line Bloodstream Infections	G	G	G	G	R	↓
		Environmental Audits	Y	G	G	Y	G	↑
		MRSA (Methicillin-resistant Staphylococcus aureus)	R	R	Y	Y	Y	↓
		Number of New Cases of Hospital Acquired Infection	G	R	R	G	Y	↑
		Percent of Sepsis Cases Reviewed by Department Head			N/A	N/A	N/A	
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
		Ventilator Associated Pneumonia	G	G	G	G	G	↑
		Ventilator Associated Pneumonia (QIP)	G	G	G	G	G	↑
		VRE (Vancomycin-resistant Enterococcus)	Y	Y	G	Y	Y	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

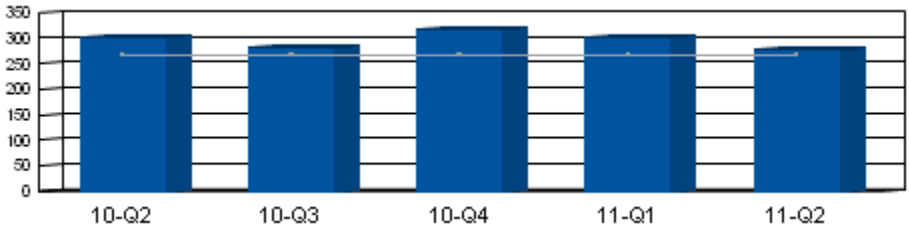
Kingston General Hospital

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-Q2	301	**267**
10-Q3	281	**267**
10-Q4	317	**267**
11-Q1	303	**267**
11-Q2	278	**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:

As of Q2, KGH's usage of antibiotics is above target but continues to trend in the right direction. In fact, since Q1 there has been an 8% drop in the rate and as a result the indicator status has gone from red to yellow. The rate of 278 is the lowest in the last 6 fiscal quarters. The Infection Prevention and Control Service continues to take the lead in implementation of an antibiotic stewardship program (ABSP) working with and through the Patient Safety and Quality Committee. The MOH has also just recently announced its intentions for a provincial 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.

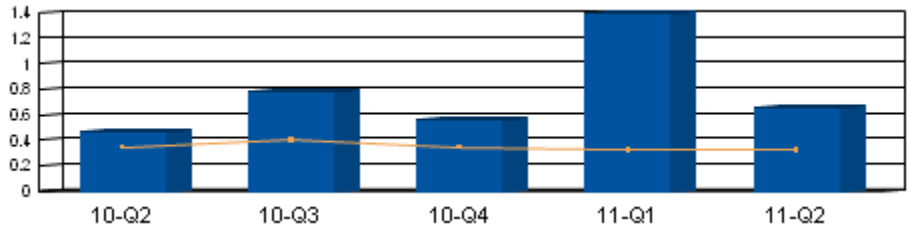
Kingston General Hospital

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-Q2	0.47	**0.34**
10-Q3	0.78	**0.4**
10-Q4	0.56	**0.34**
11-Q1	1.39	**0.32**
11-Q2	0.66	**0.32**

Interpretation - Patient And Business:

Please note: Values provided are monthly (May-Sept 2011)

Patient Perspective: The KGH rate for this quarter was 0.66 cases per 1000 patient days; a 53% drop in rate compared with the previous quarter. KGH was in a Public Health declared CDI outbreak from July 15 - October 13. This likely occurred because of increased case finding from the introduction of a more sensitive laboratory test for CDI. The outbreak was not confined to any specific geographical area of the hospital. At the same time, a number of hospitals in Ontario also experienced C. difficile infection outbreaks likely related to increased testing and public awareness with increasing prevalence of C. difficile carriage amongst both hospitalized and non-hospitalized patients. We are seeing more cases of community-acquired CDI.

Business Perspective: The response to the C. difficile infection outbreak was on three fronts. Emphasis on hand hygiene that includes the increased use of soap & water when dealing with CDI patients, rapid identification and isolation of cases, and emphasis on thorough environmental cleaning of direct patient care areas with sporocidal cleaners. The pending introduction of an Antimicrobial Stewardship Program (ASP) to proactively improve appropriate antibiotic use in the hospital will be the final component needed to maintain a four-pronged initiative to prevent CDI in the hospital.

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

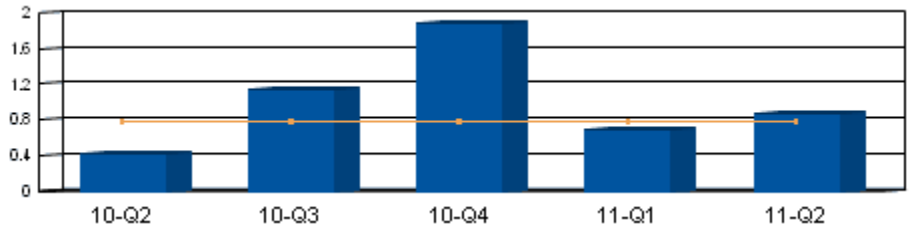
Kingston General Hospital

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 (QIP)



	Actual	Target
10-Q2	0.42	**0.77**
10-Q3	1.15	**0.77**
10-Q4	1.89	**0.77**
11-Q1	0.70	**0.77**
11-Q2	0.87	**0.77**

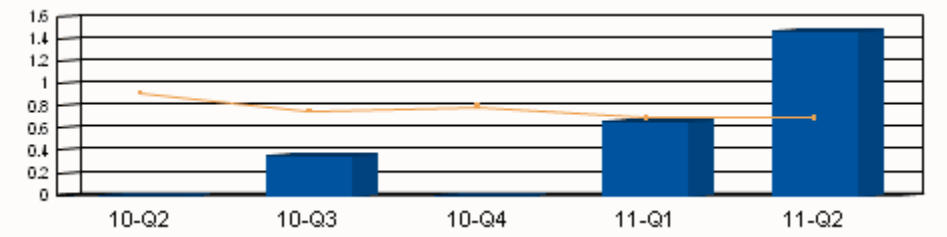
Definition: Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is 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: QIP Goal = 0.30, QIP Target for Compensation = 0.77

Indicator: Central Line Bloodstream Infections



	Actual	Target
10-Q2	0.00	**0.91**
10-Q3	0.36	**0.75**
10-Q4	0.00	**0.79**
11-Q1	0.66	**0.69**
11-Q2	1.47	**0.69**

Interpretation - Patient And Business:

Patient perspective: CLBI poses a significant risk of life threatening infection and increased critical are and hospital length of stay. Q2 results show a marked increase, however this was attributable to only 2 patients with central lines. The Critical Care program remains vigilant with respect to all infectious disease prevention practices.
Business perspective: Investigation into the cause of the jump in CLBI rates in Critical Care should be undertaken especially if rates remain above target for another quarter.

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

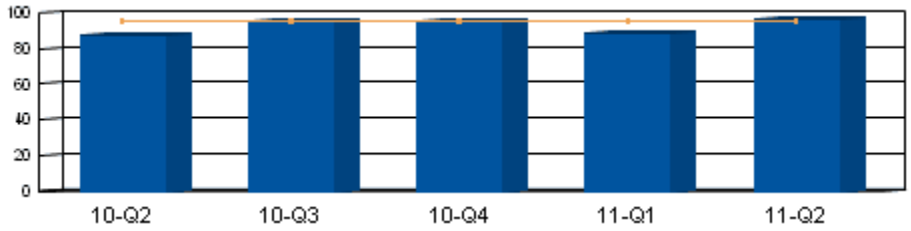
Kingston General Hospital

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: Environmental Audits



	Actual	Target
10-Q2	87	**95**
10-Q3	95	**95**
10-Q4	95	**95**
11-Q1	88	**95**
11-Q2	96	**95**

Interpretation - Patient And Business:

Recently implemented staff training program has a positive impact on our improved results.

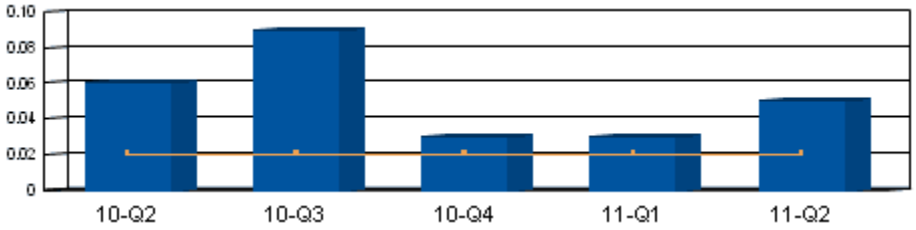
Actions & Monitoring Underway to Improve Performance:

Increased number of staff being trained and our full timers returning from vacation have contributed to meeting our target.

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%

Indicator: MRSA (Methicillin-resistant Staphylococcus aureus)



	Actual	Target
10-Q2	0.06	**0.02**
10-Q3	0.09	**0.02**
10-Q4	0.03	**0.02**
11-Q1	0.03	**0.02**
11-Q2	0.05	**0.02**

Interpretation - Patient And Business:

Patient perspective: Rates of MRSA bacteremia have remained steady over the last quarter. This can be attributed to some extent from the attainment of rates for hand hygiene >90% across KGH. MRSA is the organism most directly transmitted through health care workers hands when not properly cleaned. This is reflected also in lower rates of MRSA colonization at KGH.

Business perspective: Continued efforts to maintain high rates of hand hygiene are paying off with reductions in the rate of serious infections such as MRSA bacteremia. The use of tools like HandiAudit should help to improve and maintain the high rates of hand hygiene across the institution.

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

---

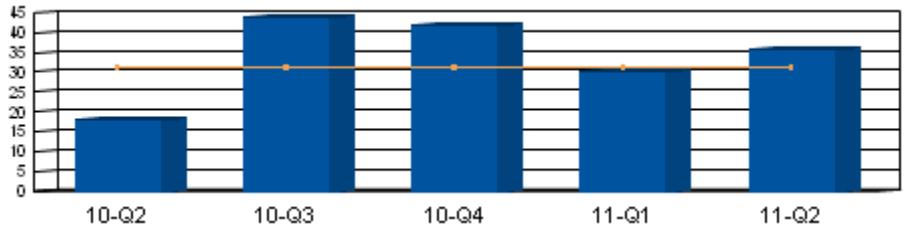
Kingston General Hospital

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: Number of New Cases of Hospital Acquired Infection



	Actual	Target
10-Q2	18	**31**
10-Q3	44	**31**
10-Q4	42	**31**
11-Q1	30	**31**
11-Q2	36	**31**

Interpretation - Patient And Business:

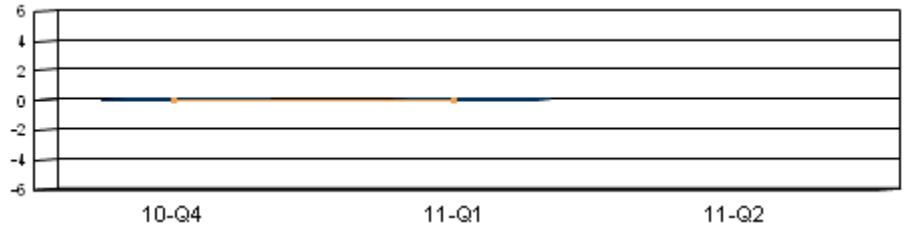
The increase in numbers likely attributable to CDI outbreak in the last quarter and a jump in CLBI in Critical Care.

Business perspective: Investment in the Antibiotic Stewardship Program should help to reduce and maintain rates of CDI. Investigation into the cause of the jump in CLBI rates in Critical Care should be undertaken especially if rates remain above target.

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

Indicator: Percent of Sepsis Cases Reviewed by Department Head



	Actual	Target
10-Q4	0	
11-Q1	0	
11-Q2		

Interpretation - Patient And Business:

Not yet being reported. Expectation is initiation in Q3

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

Target: QIP Target 11/12: 75%

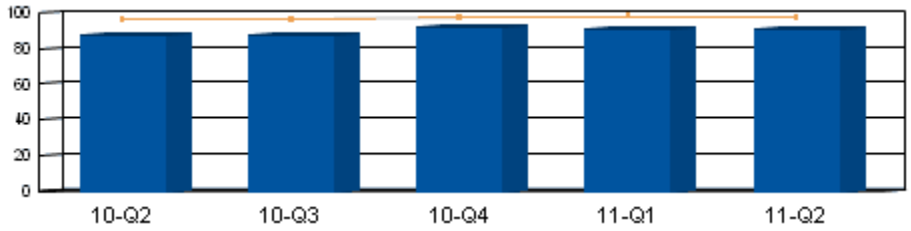
Kingston General Hospital

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: Surgical Site Infection (SSI) Prevention



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

Interpretation - Patient And Business:

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

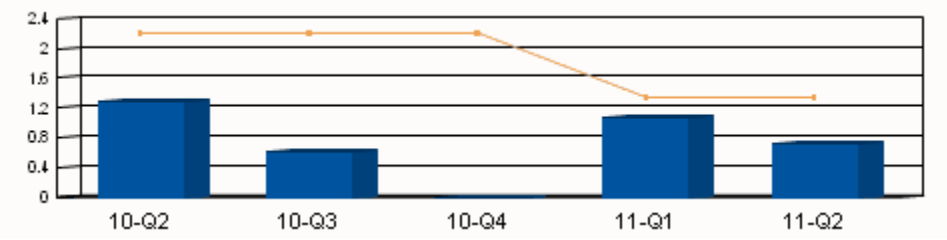
Business perspective: Identification of remaining barriers to timely antibiotic administration are being examined by the Surgical Infection Control working group.

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

---

Indicator: Ventilator Associated Pneumonia



	Actual	Target
10-Q2	1.3	**2.2**
10-Q3	0.6	**2.2**
10-Q4	0.0	**2.2**
11-Q1	1.06	**1.33**
11-Q2	0.71	**1.33**

Interpretation - Patient And Business:

Patient perspective: Consistently below target for 5 quarters with recent decrease.

Business perspective: 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

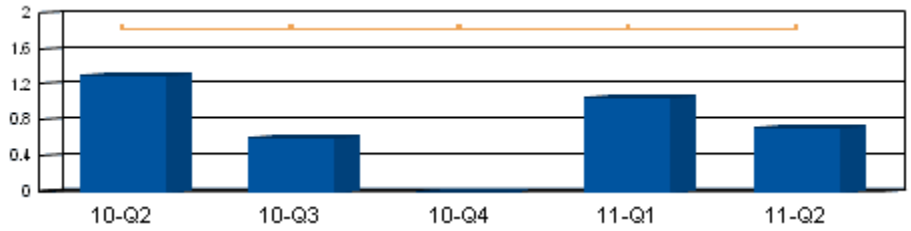
Kingston General Hospital

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 (QIP)

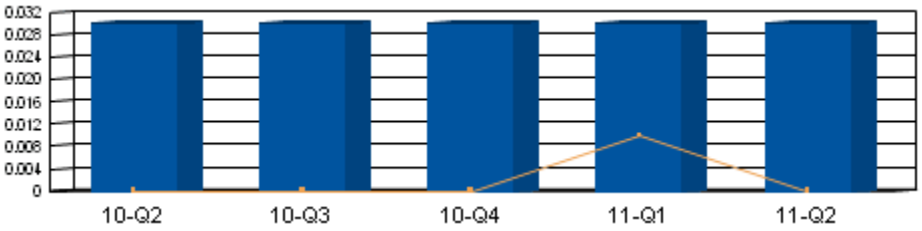


	Actual	Target
10-Q2	1.30	1.82
10-Q3	0.60	1.82
10-Q4	0.00	1.82
11-Q1	1.06	1.82
11-Q2	0.71	1.82

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

Indicator: VRE (Vancomycin-resistant Enterococcus)



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

Interpretation - Patient And Business:

Patient perspective: Very low rates of clinically relevant infection and no attributable mortality.

Business perspective: Main impact is on need to isolate patients who are colonized. Attendant isolation rates may have a direct impact on patient flow. 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 LOS

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	Yellow
Percent of Clinical Services Meeting ELOS Target	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The variance in average length of stay vs expected length of stay has shown a progressive 4 quarter positive trending with a conserved 0.6 of a day in Q1 (most recent data). This variance of -0.6 is against a target of zero and was a 50% improvement over the previous quarter (fiscal 2010, Q4). Percent ALC days has shown a 2 quarter trend decrease. Currently at 12% of total inpatient days with a target of 10%, a 14% decrease in ALC occupancy of inpatient beds. Clinical services meeting their expected length of stay has seen a 3 quarter positive trend. 67% (12 of 18) of services are at or better than their expected length of stay. With a target of 100%, a 10% improvement over the last quarter has occurred.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Program and Clinical Department support by the performance management team, concurrent review, Department presentation of data have helped support care pathways and drive change. ALC improvements have been aided by the home first initiative, CCAC support and renewed partnering with Providence Care.

3. **Are we on track to meet the milestone by year end?**
   Trending of clinical services meeting their expected length of stay will bring us close to target by year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Program support through Patient Flow Task Force and meeting with Departments to reinforce targets will continue. Focused support from concurrent review will continue on services currently not achieving ELOS.

Kingston General Hospital

Milestone #6

			10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	R	R	↑
		Overall - Acute Average Length of Stay Days (Based on HSAA)	R	Y	Y	Y	Y	↑
		Overall - Acute Average Length of Stay vs ELOS (Variance)	G	G	G	G	G	↑
		Percent ALC Days	R	R	R	Y	Y	↑
		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	R	↑
		Readmission rate Within 30 Days for Selected CMG's	G	R	N/A	N/A	N/A	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

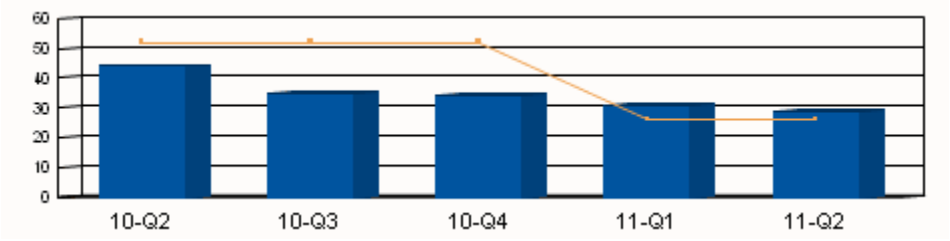
Kingston General Hospital

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-Q2	44	**52**
10-Q3	35	**52**
10-Q4	34	**52**
11-Q1	31	**26**
11-Q2	29	**26**

Interpretation - Patient And Business:

Although the reduced target has not yet been achieved on a consistent basis, the number of patients designated as ALC continues to decrease on a month by month basis. Focus remains on internal processes and process improvements with community partners that support transitions to home or alternate settings.

Actions & Monitoring Underway to Improve Performance:

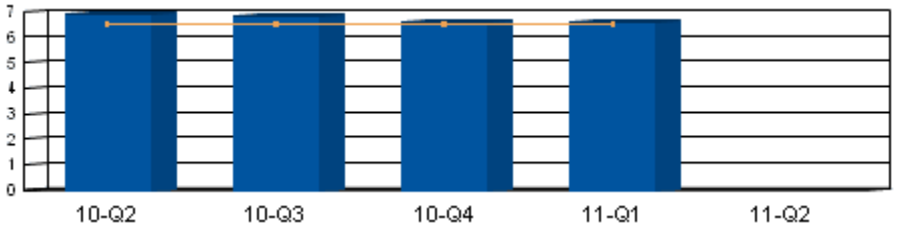
The Home First program remains a focus in all clinical areas with evidence of higher numbers of transfer to home. ALC rates, conversion rates and Home First trends are reviewed monthly at the Patient Flow Task Force with consideration of opportunities for improvement.

The 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 has been expanded to consider the needs of the mental health population. Focus is on improvements with transfer planning and communication at transition points.

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

Interpretation - Patient And Business:

The average length of stay for Q1 remains steady at 6.6 is just beyond the target of 6.5. 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:

ALOS is the focus of work within programs, in the Patient Flow Task Force and at MAC. In addition, 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.

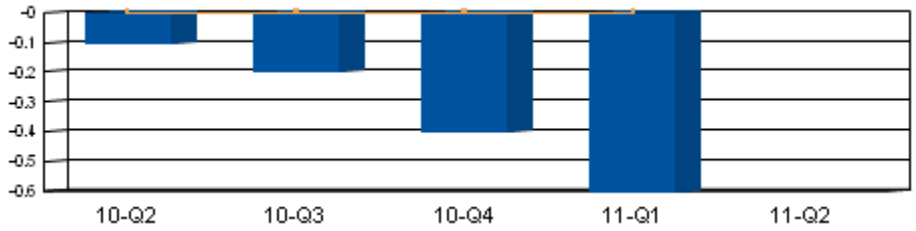
Kingston General Hospital

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-Q2	-0.1	
10-Q3	-0.2	
10-Q4	-0.4	
11-Q1	-0.6	
11-Q2		

Interpretation - Patient And Business:

Because this indicator is calculated using coded and abstracted medical record data, Q1 results are the latest complete fiscal quarter. A positive trend in overall performance continues. The -0.6 variance for Q1 (fiscal 11/12) indicates that overall our actual length of stay is below or better than our expected length of by 0.6 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 in the services of Haematology, Nephrology, Neurology, Neurosurgery, Obstetrics, and Otolaryngology.

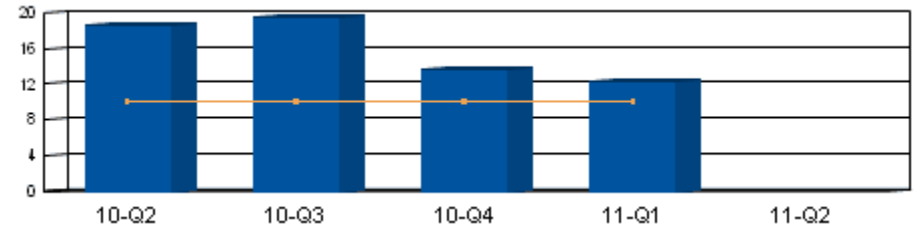
Actions & Monitoring Underway to Improve Performance:

Meetings through the Chief of Staff's office continue with individual Departments for the purpose of 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:

Indicator: Percent ALC Days



	Actual	Target
10-Q2	18.6	**10**
10-Q3	19.4	**10**
10-Q4	13.6	**10**
11-Q1	12.3	**10**
11-Q2		

Interpretation - Patient And Business:

Although the reduced target has not yet been achieved on a consistent basis, the number of patients designated as ALC continues to decrease on a month by month basis. Focus remains on internal processes and process improvements with community partners that support transitions to home or alternate settings.

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%

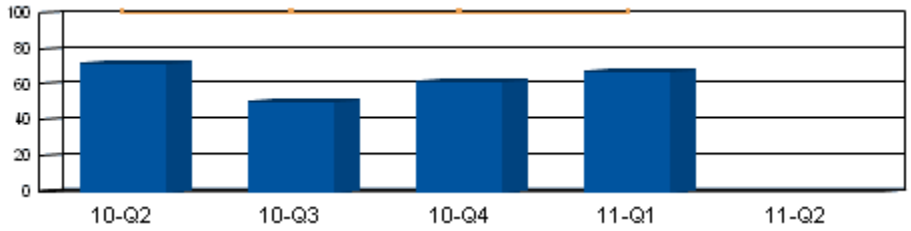
Kingston General Hospital

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-Q2	72	**100**
10-Q3	50	**100**
10-Q4	61	**100**
11-Q1	67	**100**
11-Q2		

Interpretation - Patient And Business:

Because this indicator is calculated using coded and abstracted medical record data, Q1 results are the latest complete fiscal quarter. A positive trend over the last three fiscal quarters continues however 6 clinical services as Q1 have yet to achieve their ELOS. The 67 percent of services achieving their expected length of stay for Q1 (fiscal 11/12) translates to 12 of 18 services achieving expected length of stay or better.

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%

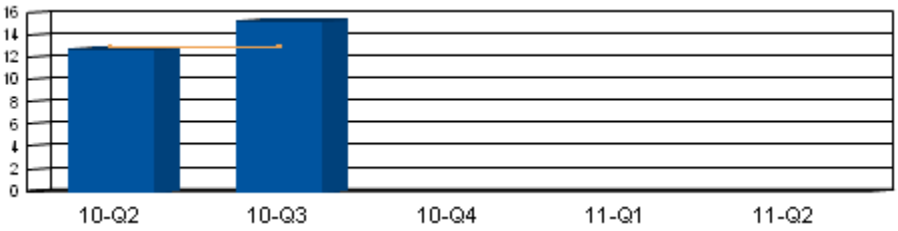
Kingston General Hospital

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-Q2	12.8	**12.9**
10-Q3	15.3	**12.9**
10-Q4		
11-Q1		
11-Q2		

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 is our actual performance on each of the indicators for this milestone as listed above?** The target is to have all admitted patients transferred out of the ED and into an inpatient bed within 8 hours of presentation to the ED. At Q2, while we continue to trend positively with 35% being admitted (which is 12% improvement relative to F11 year end), we are not meeting the target.
2. **What are the contributing factors to the current performance of the indicators for this milestone?** The patients who are awaiting admission in the ED are typically aligned to one of three programs – medicine which is showing decreased LOS but an ever increasing numbers of admissions; critical care which is still redeveloping additional bed space to meet identified needs; and mental health which is a new program to KGH and appears to be experiencing surge.
3. **Are we on track to meet the milestone by year end?** No. While the trend with each provincially reported indicator of patient flow is moving in the right direction, we are unlikely to meet the stretch target set by/for KGH. However, it is important to note that the 90th percentile wait time for admitted patients is green and at the KGH target. With respect to this measure, we have one of the lowest wait times in the province as compared to our teaching hospital peers. Positive trends are enabled by processes supporting access to inpatient beds (introduction of Medicine Short-stay Unit; Home First initiative: predicted discharge). Rates will be further improved when the critical care expansion is complete and with improvements to mental health patient flow.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Medicine is profiling those admitted, readmitted or discharged from Emergency (top 5 case mix groups) to identify community supports or processes that could prevent destabilization earlier and hence avoid admission, and foster different collaboration with primary health providers. There are many improvements to internal processes - eg Code Gridlock; Home First, discharge prediction and conditional discharge orders; bed map reconfigurations. The ED is suggesting review of the indicator (eg within 4 hours of decision to admit), as some think the target is unachievable and could inadvertently drive practices that are not in the interest of patient or system.

Kingston General Hospital

Milestone #7

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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)	Y	R	R	G	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)	Y	Y	R	G	G	↑
			Percent of Non-admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	Y	R	R	R	↓
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	Y	Y	Y	G	Y	↑
			Percent of Patients Admitted (from the Emergency Department) within a Wait Time Target of <8Hrs (SSC)	R	R	R	R	R	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

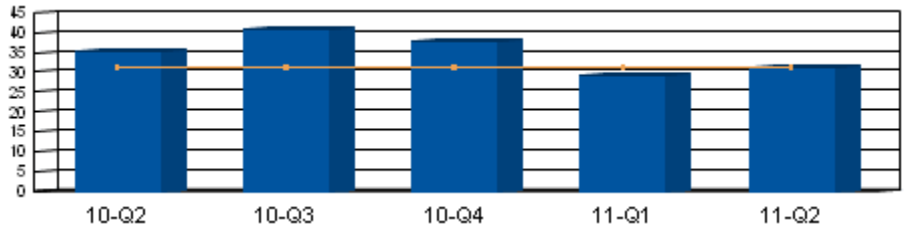
Kingston General Hospital

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-Q2	35.2	**31**
10-Q3	40.9	**31**
10-Q4	37.6	**31**
11-Q1	29.2	**31**
11-Q2	31.1	**31**

Interpretation - Patient And Business:

We are just above the target of 9/10 patients spending less than 31 hours in the Emergency Department waiting for an inpatient bed. At the end of Q2, 10% of admitted patients waited longer that 31.1 hours for an inpatient bed. This is an improvement of 4.1 hours relative to the same quarter last fiscal. A factor in the change in performance relative to Q1 may be influenced by the fact that there were 342 more admissions in Q2 than in Q1.

Note: Year 4 Pay for Results target for this indicator is 33.2 hours & at Q2 the SE LHIN imposed an HSAA target of 25 hrs

Actions & Monitoring Underway to Improve Performance:

LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning.

Number of initiatives are included as part of the ministry initiative (Pay for Results) - ie Medical Short Stay Unit, Admission Nurse.
Consultant times are also being monitored and intervention when required. Changes with bed assignment process continue to be monitored and improved.

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

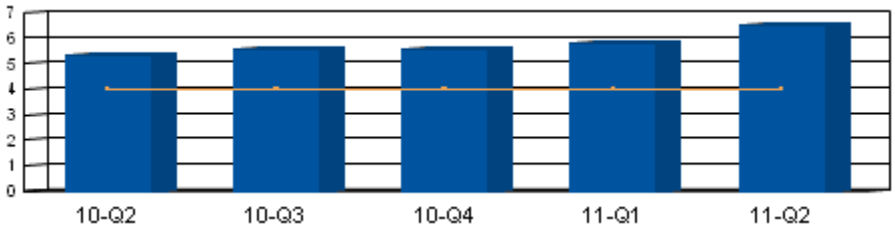
Kingston General Hospital

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-Q2	5.3	**4**
10-Q3	5.6	**4**
10-Q4	5.6	**4**
11-Q1	5.8	**4**
11-Q2	6.5	**4**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q2 results, KGH is failing to meet the ED 90th percentile wait time target of 4hrs. Ten percent of patients in this category had a total length of stay longer than 6.5 hours. The move of the MH inpatient unit in June had a significant impact on the ED and at times limited our ability to see patients in fast track on some occasions given volumes of MH health patients in the department and lack of space to use for fast track.

Visit volumes were significantly higher during Q2 with a higher proportion on high acuity patients requiring more urgent care.

Business Perspective: This is an indicator in the provincial Pay for Results program with a target of 4:52. Funding is at risk of claw back if targets are not met. In addition, 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 ($100 for each patient discharged within 4 hours over last year's baseline).

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 they are busy with more urgent patients.. As of September, additional physican hours and coverage during peak times will help to reduce the assessment time.

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.

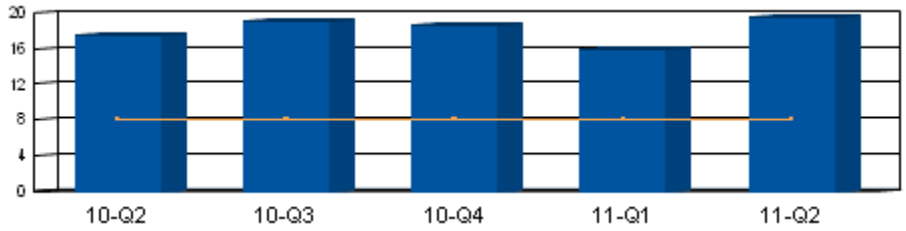
Kingston General Hospital

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-Q2	17.5	**8**
10-Q3	19.1	**8**
10-Q4	18.7	**8**
11-Q1	15.8	**8**
11-Q2	19.6	**8**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q2 results, KGH is failing to meet the ED 90th percentile LOS target of 8 hrs for admitted patients with complex conditions. 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 78 hours in this quarter. Nine of 10 patients are admitted to an inpatient bed within 19.6 hours.

Business Perspective: Volumes have been higher than expected and higher than in previous quarters particularly in the high acuity categories. Visits were 342 more than last quarter and 401 more than same period last fiscal. Admission rates have been between 17.3 and 19.3% creating a surge in Medicine which was running at 140% occupancy at times. Inefficiencies are created that have a negative financial impact on the hospital (e.g. caring for admitted patients in the Emergency Department during the most expensive part of their stay).
7 short stay medicine beds were opened in July to help decant patients out of the ED quicker. This funding is part of the provincial Pay for Results program and funding is at risk of claw back if targets are not met.

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, express beds, 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.

The Patient Flow Task Force (PFTF) meets every two weeks.

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 the decision to admit. Time from consult to the arrival of consultant service is now being tracked and publicly reported.

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.

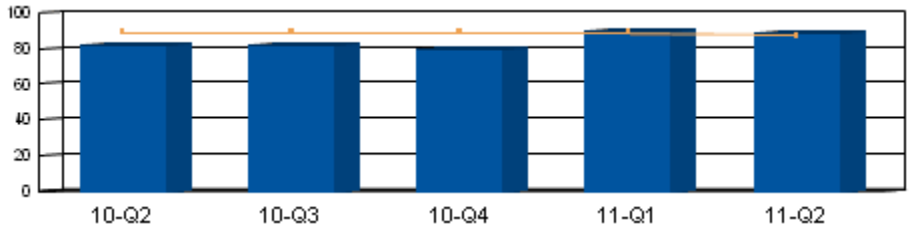
Kingston General Hospital

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-Q2	82	**89**
10-Q3	82	**89**
10-Q4	80	**89**
11-Q1	90	**89**
11-Q2	89	**87**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q2 results, the ED has improved the ED wait time achieving the 87% 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 9 percentage points over last fiscal has been sustained over the past 2 quarters.

Business Perspective: Year 4 Pay for Results funding has been received which will enable us to implement initiatives to help with patient flow. This funding is at risk of claw back if targets are not met.

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 non-admitted high acuity. KGH has a target of 7:50 at the 90th percentile based on a ten per cent improvement over last year's baseline.

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 Fast Track to include ambulatory CTAS 3 patients, realignment of medical coverage in the ED to patient arrival times as well as additional physician hours to cover busier times. Plans for a triage transition nurse will help to ensure triage is quick (within 90 seconds) and patients in this category will be brought to a stretcher quickly for 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 8 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%).
Colour coding on EDIS alerts staff if patients are approaching target time.

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%

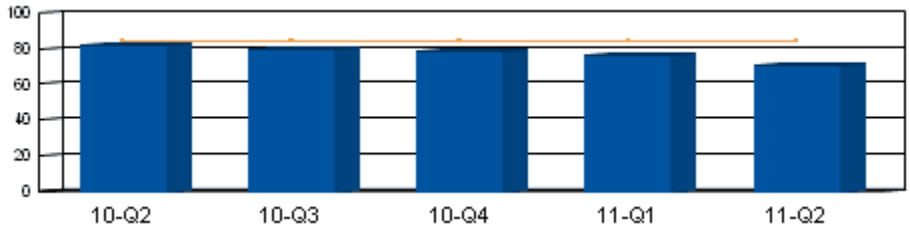
Kingston General Hospital

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-Q2	82	**84**
10-Q3	80	**84**
10-Q4	78	**84**
11-Q1	76	**84**
11-Q2	71	**84**

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%.

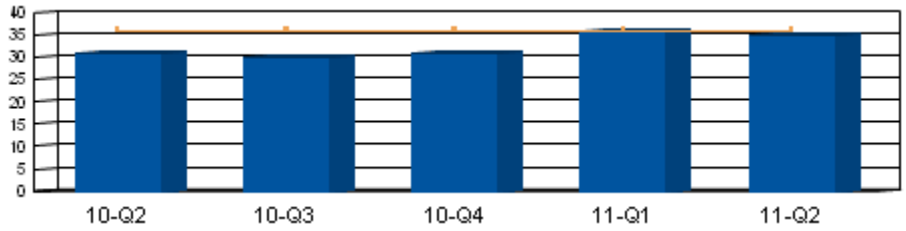
Kingston General Hospital

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-Q2	31	**36**
10-Q3	30	**36**
10-Q4	31	**36**
11-Q1	36	**36**
11-Q2	35	**36**

Interpretation - Patient And Business:

Patient Perspective: Based on Q2 results, improvements have been made over this past year. While many patients are waiting longer than 8 hours before reaching their inpatient bed, 35% are moving within the 8 hour target.
Those that wait longer than 8 hours are waiting an average of 19.1 hours at the 90th percentile. Inpatient days in ED this quarter were 848 days which is 119 days more than the previous quarter.

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 patients admitted requiring specialized services, i.e. isolation, critical care and mental health impacts the ability to quickly move these patients to an inpatient bed.

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. This target is now measured at the 90th percentile under the provincial program with a target of 33.2 hours based on a 10% improvement over last year's baseline.

Actions & Monitoring Underway to Improve Performance:

KGH continues to be part of the Provincial Pay for Results Program for the 4th consecutive year. Additional flex capacity has been built in with the opening of 7 new short stay medicine beds in July (express beds). These beds are funded under the provincial pay for results program. Funding is at risk if targets are not met.

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. This time from consult request to consultant arrival in ED is now being measured and monitored.

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".

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%.

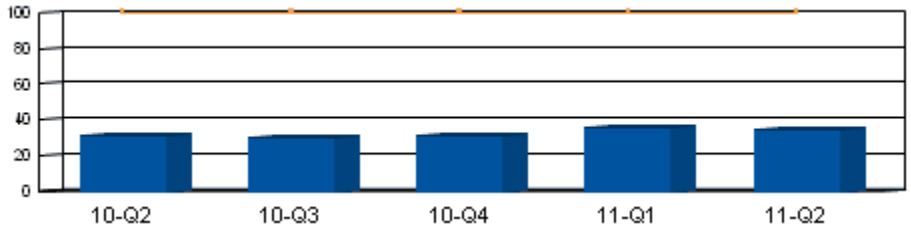
Kingston General Hospital

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-Q2	31	**100**
10-Q3	30	**100**
10-Q4	31	**100**
11-Q1	36	**100**
11-Q2	35	**100**

Interpretation - Patient And Business:

We are not meeting the 100 percent target set by KGH. In order to meet these targets significant improvements in the movement of admitted patients from the ED must occur.

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. LOS continues to be monitored.

Staffing the flex beds and overcapacity beds has been challenging and has contributed to delays in moving patients to these beds. Surges in Medicine, Critical Care (level 2) and Mental Health all contribute to challenges with bed availability.

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 is our actual performance on each of the indicators for this milestone as listed above?**
   A 90% target of surgical services meeting or exceeding the 90th percentile wait time target has been reached by 33 out of 44 surgical categories (75%). This is a 5% decrease from the previous quarter but still a 8% improvement from the end of fiscal 2010.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Surgical program leadership closely monitors the progress in conjunction with the Wait Times Committee. Surgical recruitment and competing priorities challenges the 90% target in Pediatric ENT surgery and non-total joint orthopedic surgeries. MRI access is trending well with the new recruitment of technicians; 90th percentile improvement in wait times will lag.

3. **Are we on track to meet the milestone by year end?**
   As of Q2, we are at risk of not achieving this target by year end. Although we are trending well and will see improvement on most surgical programs, there are issues in a few that will not be solved in the current fiscal year.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The Wait Times Strategy Committee with the performance management team will continue to support the Surgical Program Leadership in monitoring progress and opportunities to improve access. Despite the challenges of working with 90th percentile wait times, average and median wait times have shown a significant improvement in the larger programs (non -joint orthopedic surgery). Adjustments to the operating room schedule to improve access to general emergency time and orthopedic trauma room time especially on weekends will help significantly to address waiting times.

Kingston General Hospital

Milestone #8

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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)	R	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	G	G	G	G	↑
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	R	R	G	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	R	↑
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	G	G	R	↓

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

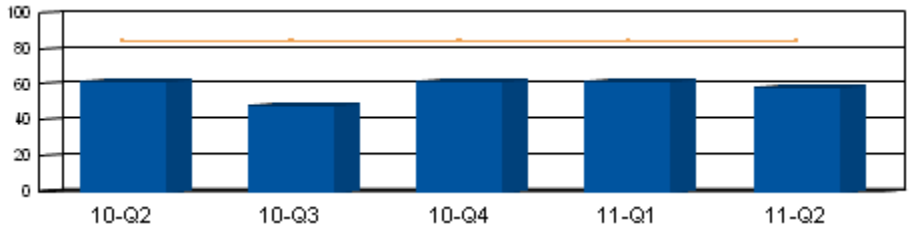
Kingston General Hospital

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-Q2	61	84
10-Q3	48	84
10-Q4	62	84
11-Q1	61	84
11-Q2	58	84

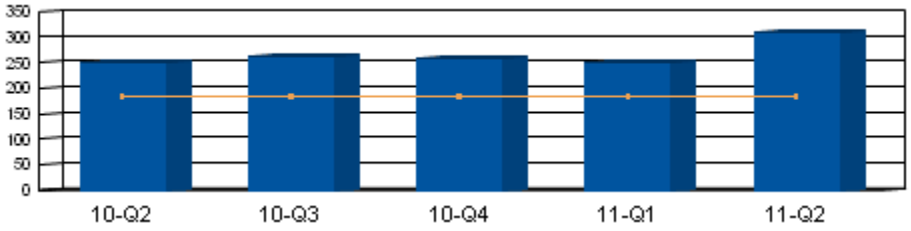
Interpretation - Patient And Business:

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-Q2	250	182
10-Q3	263	182
10-Q4	258	182
11-Q1	250	182
11-Q2	310	182

Interpretation - Patient And Business:

The pediatric wait times for this indicator continue to be directly influenced by the ENT procedure activity. The 90th percentile wait for Pediatric ENT in this quarter is 454 days with a peak of 654 days in September which is a substantial increase from last quarter.

There is currently no wait list for Pediatric General Surgery as patients had been referred to other centres until the two 0.5FTE positions were filled.

Actions & Monitoring Underway to Improve Performance:

New 0.5FTE pediatric surgeon started on August 8th bringing the service to 1.0FTE for general surgery. Physician resources are currently the challenge in fulfilling the ENT volumes/wait times although recruitment is underway to fill the position.

Monitoring by program leadership and service is underway and will include a review of wait time list coding with staff in the physicians offices.

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.

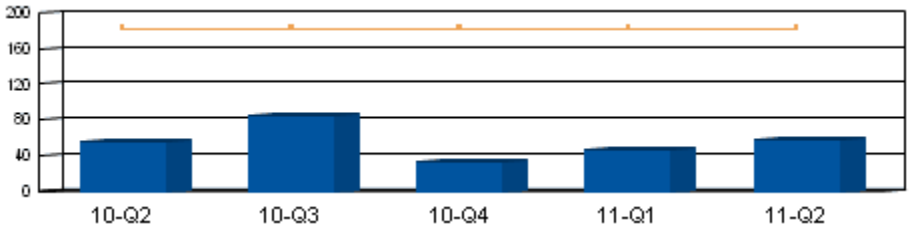
Kingston General Hospital

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-Q2	56	**182**
10-Q3	85	**182**
10-Q4	33	**182**
11-Q1	46	**182**
11-Q2	57	**182**

Interpretation - Patient And Business:

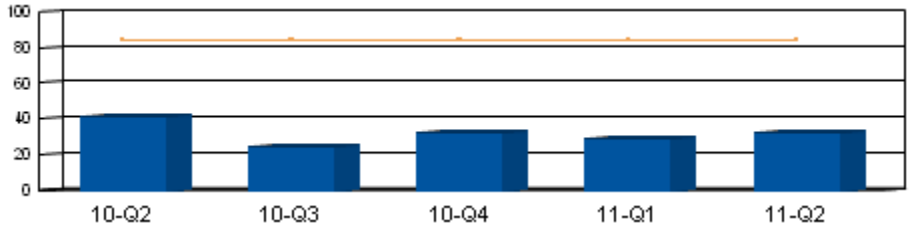
This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

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-Q2	41	**84**
10-Q3	24	**84**
10-Q4	32	**84**
11-Q1	29	**84**
11-Q2	32	**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.

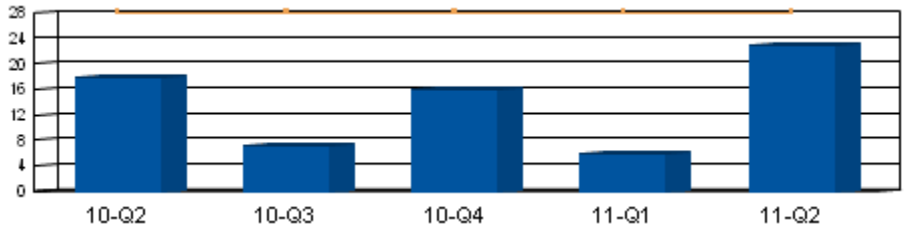
Kingston General Hospital

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-Q2	18	**28**
10-Q3	7	**28**
10-Q4	16	**28**
11-Q1	6	**28**
11-Q2	23	**28**

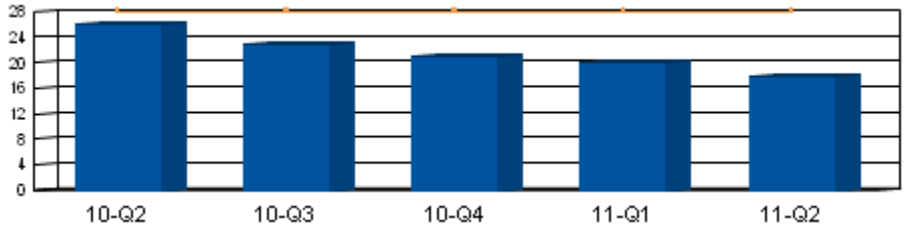
Interpretation - Patient And Business:

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-Q2	26	**28**
10-Q3	23	**28**
10-Q4	21	**28**
11-Q1	20	**28**
11-Q2	18	**28**

Interpretation - Patient And Business:

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

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.

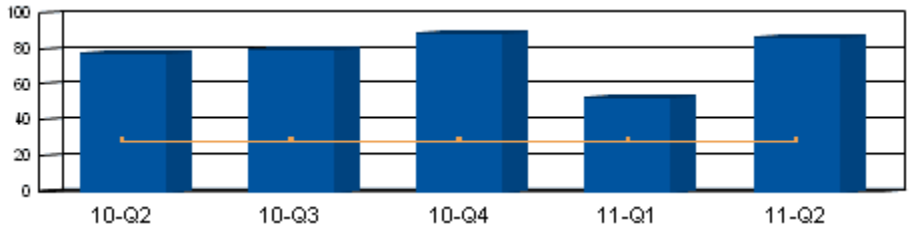
Kingston General Hospital

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-Q2	77	**28**
10-Q3	80	**28**
10-Q4	89	**28**
11-Q1	53	**28**
11-Q2	86	**28**

Interpretation - Patient And Business:

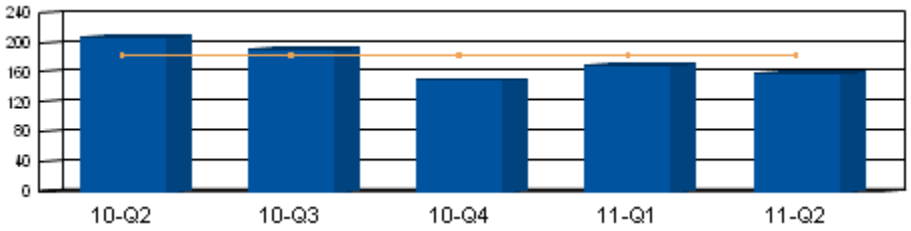
The jump to 86 days is a result of the expanded MRI hours post summer vacation and the completion of training/orientation of a new employee. Our expanded hours allowed us to address the lower Priority cases which had the largest wait times. Closing these studies off drove up our wait times. Expansion of hours and focus on catching up on lower priorities may see a trend of higher wait times as we address more of the Priority 3 and 4 cases.

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

---

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



	Actual	Target
10-Q2	207	**182**
10-Q3	192	**182**
10-Q4	149	**182**
11-Q1	169	**182**
11-Q2	159	**182**

Interpretation - Patient And Business:

This KPI has been shaded "green" for the past 4 quarters and continues to trend positively as a result of increased operating hours both during the evening hours and on weekends.

Actions & Monitoring Underway to Improve Performance:

Close monitoring with the service and program leadership will support the ongoing positive trending for this indicator.

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.

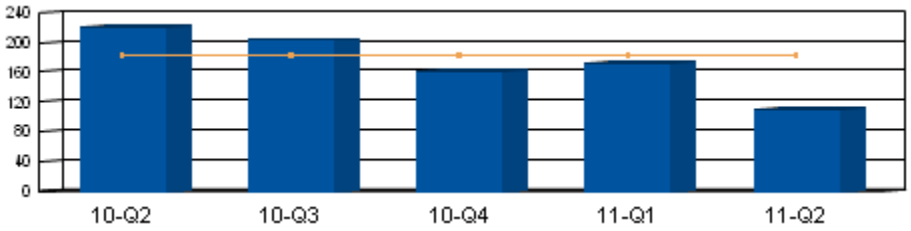
Kingston General Hospital

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



	Actual	Target
10-Q2	221	182
10-Q3	203	182
10-Q4	161	182
11-Q1	173	182
11-Q2	111	182

Interpretation - Patient And Business:

This indicator has remained as status "green" for the 3rd quarter and is related to additional evening operating room time that commenced in June 2011 as well as the success of the HDH hip and knee short stay program.

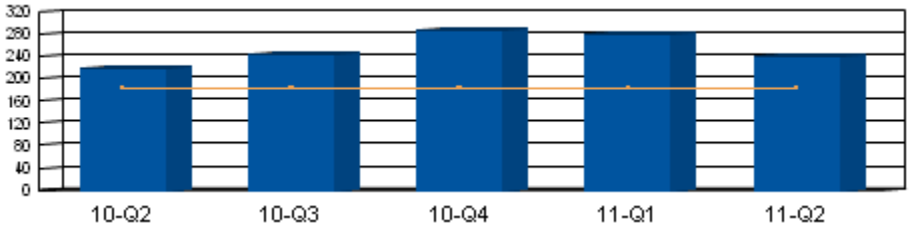
Actions & Monitoring Underway to Improve Performance:

Consistent efforts by the program to monitor and evaluate progress on a monthly basis should assist in maintaining the below target result.

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.

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



	Actual	Target
10-Q2	217	182
10-Q3	242	182
10-Q4	286	182
11-Q1	281	182
11-Q2	240	182

Interpretation - Patient And Business:

This KPI although shaded red has started to trend more positively this last quarter. The median wait for this quarter is 95 days which is a vast improvement from the last quarter of 246 days. It is anticipated that this trend should continue into the next quarter as a result of additional weekend ortho trauma operating room that commenced September 17th, 2011.

Actions & Monitoring Underway to Improve Performance:

Wait times are monitored monthly at a joint HDH / KGH Wait List Committee meeting. Meetings with program and division head leaders are planned to collaboratively strategize on further improvement in meeting targets.

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.

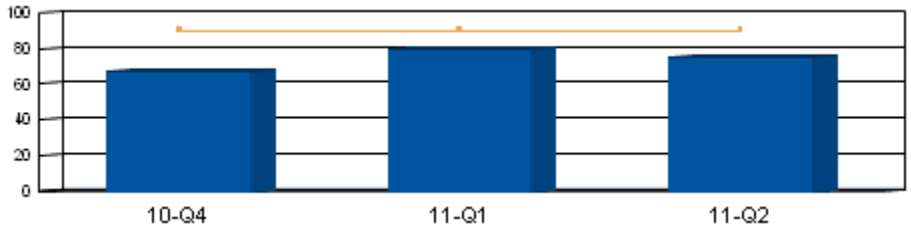
Kingston General Hospital

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



	Actual	Target
10-Q4	67	90
11-Q1	80	90
11-Q2	75	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.

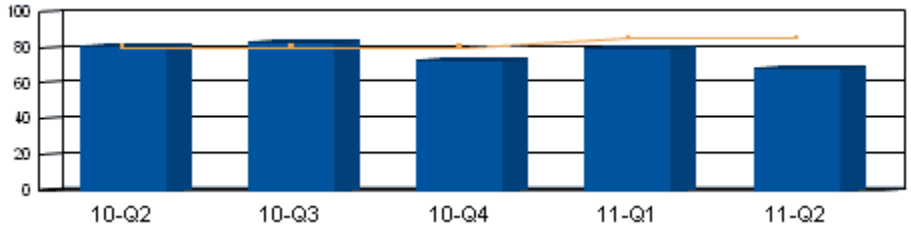
Actions & Monitoring Underway to Improve Performance:

The Q2 results indicate that the target of 90% has still not been reached and a 15% improvement is still required. As of Q2, 33 out of 44 Surgical wait categories were meeting the MOH 90th percentile wait time target. 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%

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



	Actual	Target
10-Q2	81	80
10-Q3	83	80
10-Q4	73	80
11-Q1	80	85
11-Q2	68	85

Interpretation - Patient And Business:

Q2 results show an overall wait time of 68.0% 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%.

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 ICPM in all inpatient units and extended to ambulatory settings by March 2012	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?** All inpatient units have implemented ICPM. All ambulatory areas included in the plan to be rolled out in Q2 have been launched successfully. These areas include Endoscopy, Out Patient Procedure Unit (OPPU), Post Anesthetic Recovery and Same Day Admission Centre (SDAC).

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The project oversight by the ICPM Steering Committee and the project manager working collaboratively with the manager of each clinical area have been key conditions to each area being ready to launch and in meeting the time lines for roll out.

3. **Are we on track to meet the milestone by year end?** Yes. Work is well underway for the launches planned for Q3 (Renal unit and all dialysis satellite units; Diagnostic Imaging and Laboratories). The only area currently at risk is the Laboratories where departmental challenges with competing projects has limited orientation and planning. Decision is being made regarding the timing of the Lab rollout in Q3 or Q4. There is confidence that all areas will be complete by fiscal year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** There may be adjustment in schedule for the Labs from Q3 to Q4. A major focus with the ICPM is the ongoing evaluation of the implementation. The results from the pre and post surveys of 4 inpatient units shows variation between clinical areas and differences in whether greater gains have been made with patient or provider satisfaction. All areas shows improvement with system/utilization indicators. Each unit team has developed an action plan to address issues that should improve performance, and these will be shared with all other units where ICPM has been implemented. With the full roll out of ICPM nearing completion, there will be heightened focus on sustainability and improvement.

Kingston General Hospital

Milestone #9

				10-Q4	11-Q1	11-Q2
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	N/A	G	G

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

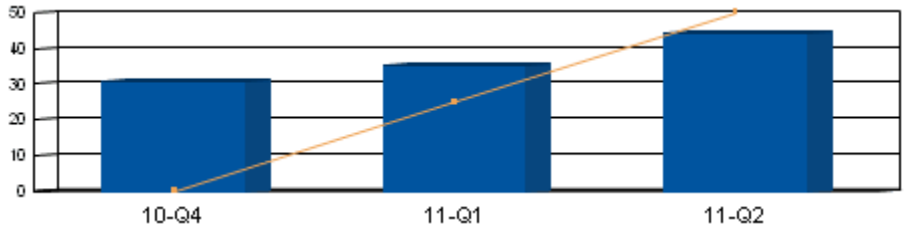
Kingston General Hospital

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	
11-Q1	35	**25**
11-Q2	44	**50**

Interpretation - Patient And Business:

The target is set at100 percent. By Q2, 22 of 51 (44 percent) of patient care areas have implemented ICPM and implementation is on track. In Q2, ICPM was implemented in the Post-Anesthetic Care Unit, Same Day Admission Centre, Outpatient Procedure Unit and Endoscopy.

The Human Resources Team has reviewed 20 provider and support roles in ambulatory areas ensuring that everyone is working to their full scope of practice.,

The Process Redesign Team has worked with each individual unit during the pre-implementation planning phase to identify process issues specific to those area. The team has been working with Transportation Services to resolve issues with delays related to patient transport.

The Documentation Team implemented the consolidated patient record project where the complete record including flowsheet and medication administration record is housed in wall desks outside patient rooms on Connell 9.

The EducationTeam facilitated education sessions for 90 staff from the ambulatory care areas listed above during this quarter . As of Q2, 1,320 staff has attended ICPM education sessions.

Actions & Monitoring Underway to Improve Performance:

Pre-ICPM patient and provider satisfaction surveys have been distributed in the Operating Room, Renal Unit, Diagnostic Imaging and Kingston Satellite Dialysis Units. This data will serve as a baseline with which we will compare post survey data to see if the changes made with ICPM have been effective in these areas.

Evaluation continues at 24 months post implementation on 5 inpatient care units. Success to date continues to be monitored for sustainability and advancement. Action plans are being developed for each satisfaction survey item that has a negative trend from pre-ICPM to 16 months post-ICPM implementation.

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%

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 is our actual performance on each of the indicators for this milestone as listed above?** The Interprofessional Education (IPE) Steering Committee continues to meet on a monthly basis with active interest and engagement of all members in delivering on the expectations outlined in the strategy. Three of the five support teams began their meetings in September (Accreditation Alignment Team, Environmental Factors and Support Team, Interprofessional Events Planning Team), and are developing their individual work plans. The Evaluation Committee and Communication Team will convene in Q3.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The change management infrastructure (having a project charter and project manager in place to guide and support activities and to oversee timelines) has been a factor in delivering on this milestone. As well, the alignment to the work with the Interprofessional Collaborative Practice Model informs the work on IPE.

3. **Are we on track to meet the milestone by year end?** Yes. The charter and high level workplan is in place and being implemented. There is plan to work with the communication team to profile the initiative within the organization in Q4.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** In addition to overseeing the work of the support teams, the IPE Steering Committee is reviewing accountabilities of an organization related to training professional staff to determine if there are gaps and opportunities for improvements at KGH. As well, the committee is reviewing the current process for receiving, reviewing, reporting and utilizing patient feedback as it relates to learners and the learning environment with the goal of influencing improvements to interprofessional practice and education.

Kingston General Hospital

Milestone #10

				10-Q4	11-Q1	11-Q2	
SD2 Bring to life new models of interprofessional	The KGH Interprofessional education council		IPE Work Plan Launched	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

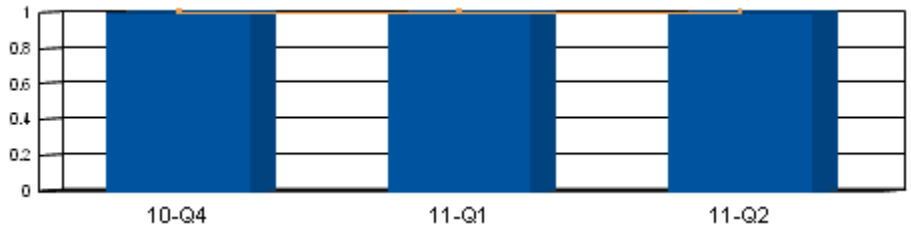
Indicates improving performance to target over the past 5 quarters ↑

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**
11-Q2	1	**1**

Interpretation - Patient And Business:

The Interprofessional Education Steering Committee meets monthly and three of the four subcommittees convened for the first time in 2011 September to develop their individual work plans. These subcommittees have representation from Kingston General Hospital, Queen's University, St. Lawrence College and the Professional Association of Interns and Residents of Ontario.

Actions & Monitoring Underway to Improve Performance:

The Interprofessional Education Steering Committee reports to the Operations Committee and provided updates and terms of reference in 2011 August. The Operations Committee approved the project charter on 2011 September 8.

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	Red

1. What is our actual performance on each of the indicators for this milestone as listed above?

Our efforts to cultivate a culture of patient-oriented research at KGH continue to expand through the recruitment of clinician scientists, through ongoing research planning, including the plan for cancer research at KGH, as well as through the creation of the KGH Research Institute. As of Q2, the clinician scientist program has a status of green with 4 potential clinician scientist candidate identified, two of which have accepted offers (Emergency Medicine, Pathology and Molecular Medicine) and will arrive in 2012.

Externally funded research dollars at KGH is measured on an annual basis. Based on current trends, we anticipate meeting the target by fiscal year end.

A preliminary needs assessment for the research institute has been completed. It includes a draft floor plan for a new Clinical Investigation Unit. A final needs analysis will be disseminated to EMC by the end of Q3.

2. What are the contributing factors to the current performance of the indicators for this milestone?

Our success has been fostered through KGH's commitment and the cooperation of SEAMO and the Faculty of Health Science on our common quest to establish leadership in the Canadian health research domain.

3. Are we on track to meet the milestone by year end?

Yes. We have already exceeded our target of one new clinician scientist recruited. Based on current trends, we anticipate meeting our target of increasing research dollars by 10% by fiscal year end. The research institute business and operating plan are well underway and will be delivered by year end.

4.What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?

There is no requirement for corrective actions at this time as our milestone is on track to be met by year end.

Kingston General Hospital

Milestone #11

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	Y	Y	G	G	G	↓
			Expand Number of Clinician Scientists				G	G	
			New Clinical Trials	G	G	G	G	R	↓
			Percent Increase of Externally Funded Research Dollars at KGH				N/A	G	
			Research Institute Business and Operating Plan Delivered				R	R	

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

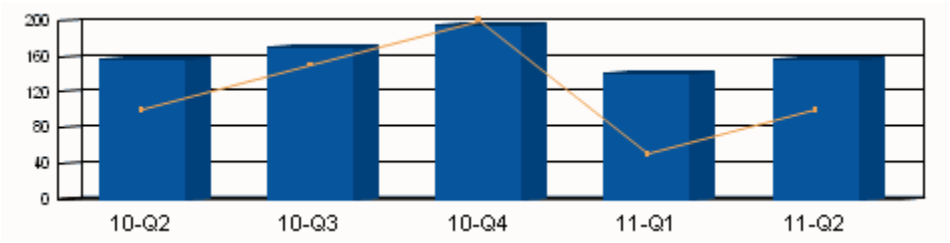
Kingston General Hospital

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-Q2	156	**100**
10-Q3	170	**150**
10-Q4	196	**200**
11-Q1	140	**50**
11-Q2	157	**100**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q2.

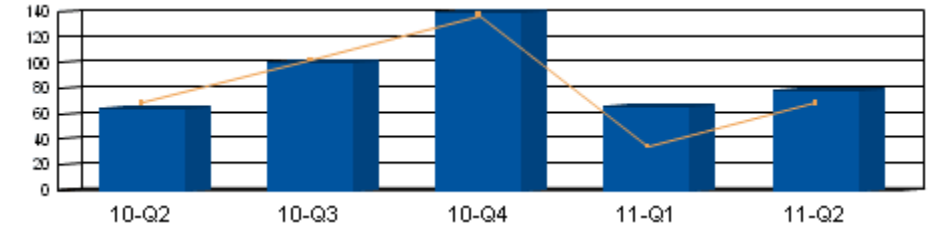
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the second quarter (Q2).

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-Q2	64	**68**
10-Q3	100	**102**
10-Q4	139	**137**
11-Q1	66	**34**
11-Q2	79	**68**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q2.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the second quarter (Q2).

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**
11-Q2	1	**1**

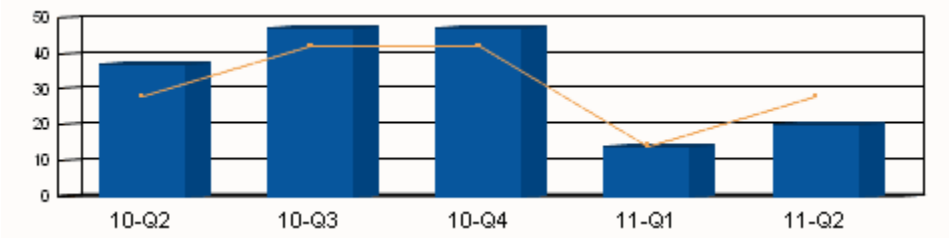
Interpretation - Patient And Business:

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-Q2	37	**28**
10-Q3	47	**42**
10-Q4	47	**42**
11-Q1	14	**14**
11-Q2	20	**28**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q2.

Business Perspective: Based on the fiscal year to date, KGH is behind its target by the end of the second quarter (Q2). As per our Affiliation Agreement with Queen's University, clinical trial contracts, agreements and grants are administered primarily by the Queen's Office of Research Services' Contracts Office.

ACAHO/CIHR/RX&D have created a model Clinical Trial Agreement (CTA) template for phase 2 and 3 clinical drug trials. Queen's has agreed to participate in the pilot of this model CTA for negotiating new clinical trials. This will hopefully help to expediate the start up of new 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: 53 Trials, Target 09/10: 56 Trials (5% increase), Target 10/11: 56 Trials. Target 11/12: 56 Trials.

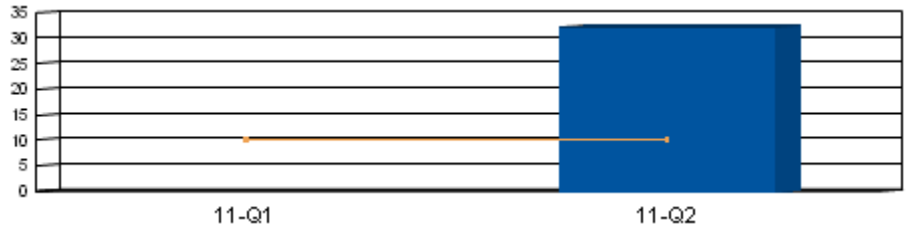
Kingston General Hospital

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
11-Q2	32	10

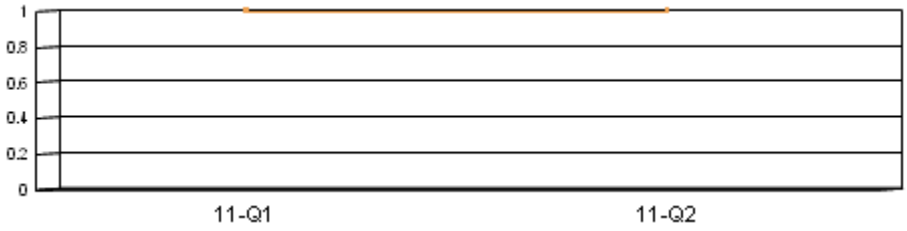
Interpretation - Patient And Business:

Real F2011 data will be used for reporting of F2012 data for this performance indicator since real figures for F2012 will not be available until September 2012. 95% of the data is obtained from external sources and is not available on a quarterly basis for reporting.

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
11-Q2		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	Green
KGH Participation in Clinical Services Roadmap Initiatives	Green

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Cancer care at KGH began its engagement and formulation of a strategic plan aligning to the KGH 2015 Strategy. Extensive enterprise wide engagement is currently underway. KGH continues to participate in the SE LHIN Clinical Services Roadmap initiative. It is about to undertake facilitated session to begin a process to evaluate and assess feasibility of staged implementation of projects.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The clinical services roadmap will have challenges of resource availability to meet all initiatives. Staging and prioritization will be balanced against the LHIN's appeal to meet very tight timelines.

3. **Are we on track to meet the milestone by year end?**
   Yes. The Cancer Care at KGH strategy is on track for end of the fiscal year. The clinical services roadmap is currently following process set out by the LHIN.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   A group of regional leaders will meet November 15 to begin assessing process to implement the clinical services roadmap.

Kingston General Hospital

Milestone #12

				11-Q1	11-Q2
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		KGH Cancer Care Plan	G	G
			KGH Participation in Clinical Services Roadmap Initiatives	G	G

Indicates worsening performance to target over the past 5 quarters 

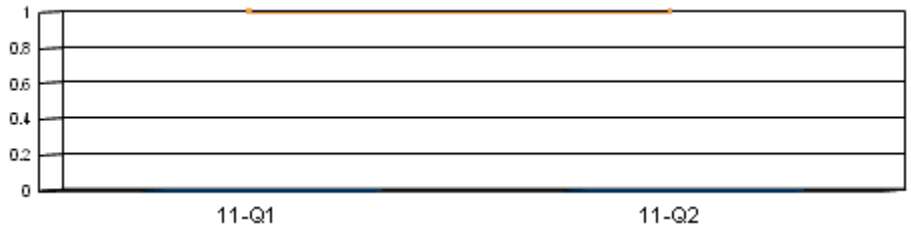
Indicates improving performance to target over the past 5 quarters 

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



	Actual	Target
11-Q1	0	**1**
11-Q2	0	**1**

Interpretation - Patient And Business:

The process to develop the Cancer Care Strategy for KGH is on track. Target completion - end of Q4 F12.

Actions & Monitoring Underway to Improve Performance:

Extensive enterprise-wide engagement is underway in developing the Cancer Care Strategy for KGH.

As we move through the process, we will be documenting our approach and lessons learned to facilitate the development of strategies for other clinical programs at KGH.

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

Indicator: KGH Participation in Clinical Services Roadmap Initiatives

	Actual	Target
11-Q1	1	**1**
11-Q2	1	**1**

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	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The target is 100% of Wait time contracted volumes achieved. At Q2 50% of volume contracts were on target. This is a 14% improvement from Q1. As of Q2, there were 5 incremental volume contracts that were not on target (total joint replacements, intestinal and ventral hernia surgery, scoliosis repair, and MRI hours). Every effort is being made to maximize Hotel Dieu Hospital capacity where possible.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Each volume contract comes with its own set of challenges; some relate to the availability of cases, ie: is there enough demand for the service? In others, it relates to the availability of medical person power. In the case of total joint replacements, it is a combination of both factors, coupled with competing total joint programs locally and regionally.

3. **Are we on track to meet the milestone by year end?**
   We are not on track. The most notable is the hip and knee replacement. Base volumes will not be met and thus the 35 incremental case volumes have been released back to the SE LHIN for redistribution.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   The Wait List Strategy Committee and the Surgical Program are continuing to closely monitor the contracted volumes. Increase operating room capacity and improvements in efficiencies will help to optimize the remaining volume contracts.

Kingston General Hospital

Milestone #13

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	G	Y	G	G	G	↑
			Ambulatory Care Volumes	G	G	G	G	G	↑
			Cardiac - Angiography Volumes	G	G	G	G	G	↑
			Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
			Cardiac - Bypass 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)	Y	G	G	Y	Y	↓
			Kidney Transplants	Y	Y	Y	G	G	↑
			MRI Hours (Wait Time Strategy Allocation)	G	G	R	G	Y	↓
			OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑

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

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

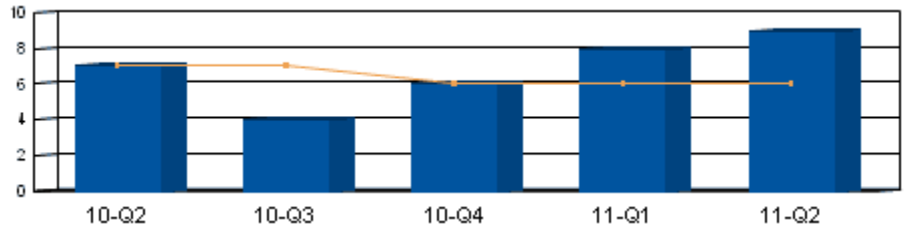
Kingston General Hospital

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-Q2	7	**7**
10-Q3	4	**7**
10-Q4	6	**6**
11-Q1	8	**6**
11-Q2	9	**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 Q2 2011/12, 9 stem cell transplants were completed.

Based on 9 completed transplants in Q2, and 8 completed transplants in Q1, KGH is still within its base funding for this procedure and has funding capacity over Q3 and Q4 of 2011/12 to complete 8 additional transplants.

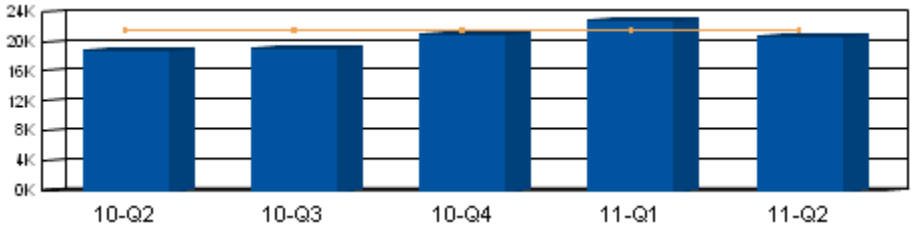
Actions & Monitoring Underway to Improve Performance:

In line with KGH's strategic direction for complex and specialty care, KGH is the only provider of autologous stem cell transplants in the SE region. It continues to provide timely access to this important cancer treatment modality to patients referred to KGH. KGH maximizes incremental funding available from Cancer Care Ontario to offer this treatment closer to home.

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-Q2	18833	**21400**
10-Q3	19067	**21400**
10-Q4	21050	**21400**
11-Q1	22878	**21400**
11-Q2	20797	**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

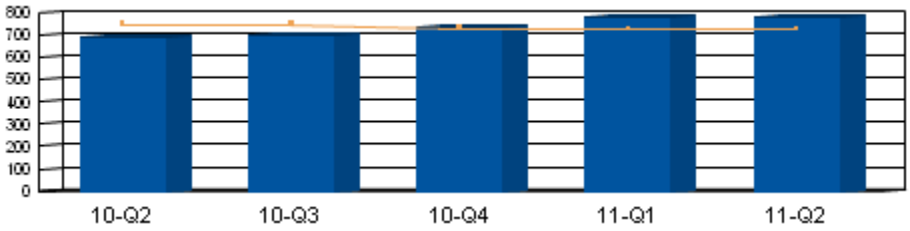
Kingston General Hospital

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-Q2	689	**748**
10-Q3	700	**748**
10-Q4	731	**729**
11-Q1	779	**725**
11-Q2	777	**725**

Interpretation - Patient And Business:

Target is 725.

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

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

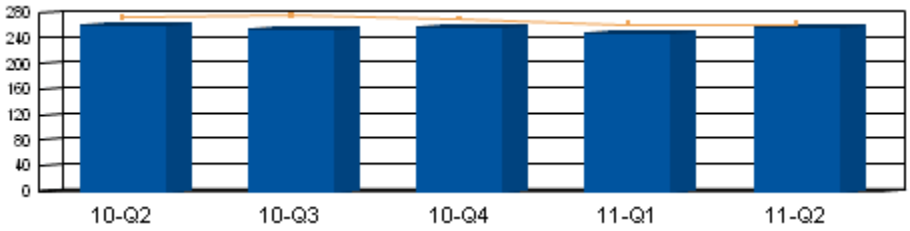
Kingston General Hospital

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-Q2	262	**272**
10-Q3	255	**275**
10-Q4	257	**270**
11-Q1	249	**262**
11-Q2	256	**262**

Interpretation - Patient And Business:

Target is 262.

Patient Perspective: 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 and are done as urgent or emergent cases with very few being elective (scheduled). 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. With the expanded area now included in the STEMI protocol, more patients with a ST elevation myocardial infarction (heart attack) in the region are coming directly to the cath lab resulting in more timely intervention.

Business Perspective: KHG is slightly below target at the end of Q2 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 and reported 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.

KGH has 3 Regional Cardiac Care Coordinators and 2 data entry clerks on site.

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 11/12: 1150

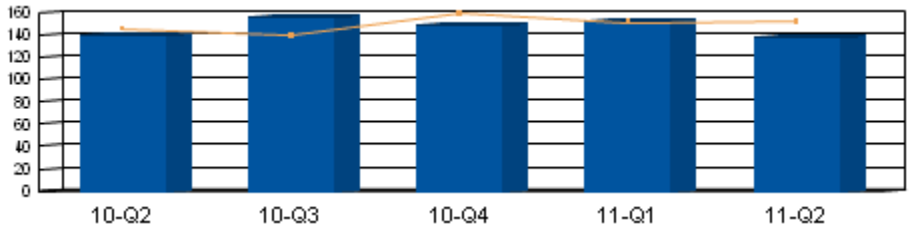
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
10-Q2	139	**145**
10-Q3	156	**139**
10-Q4	148	**159**
11-Q1	153	**151**
11-Q2	138	**152**

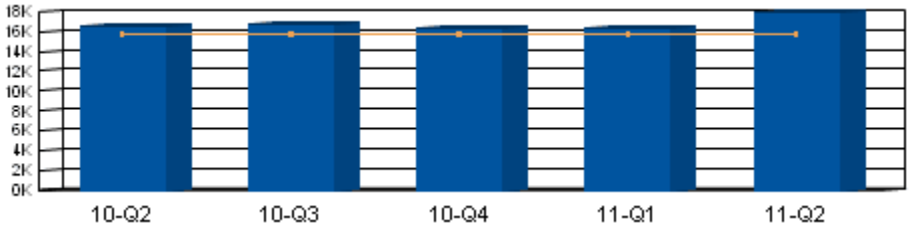
Interpretation - Patient And Business:

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 procedures are one of the selected 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.

Target: Target 10/11: 580, Target 11/12: 606

Indicator: Chronic Kidney Disease Program- Weighted Units



	Actual	Target
10-Q2	16562	**15655**
10-Q3	16723	**15655**
10-Q4	16290	**15655**
11-Q1	16265	**15655**
11-Q2	17888	**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

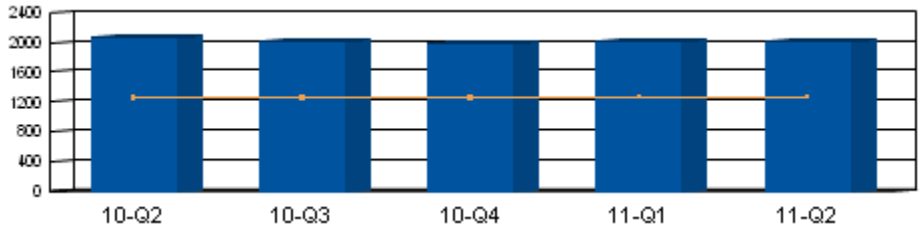
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
10-Q2	2068	**1247**
10-Q3	2009	**1247**
10-Q4	1987	**1247**
11-Q1	2012	**1263**
11-Q2	2015	**1263**

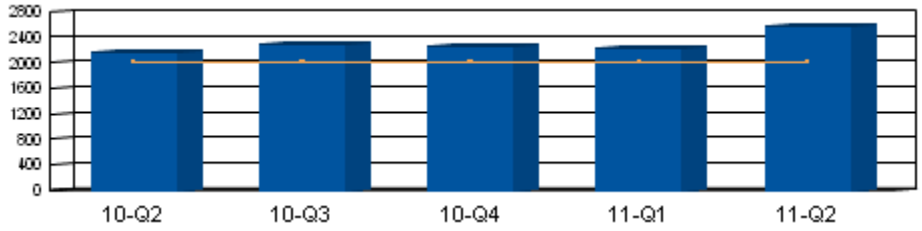
Interpretation - Patient And Business:

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. 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.

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



	Actual	Target
10-Q2	2175	**2002**
10-Q3	2288	**2002**
10-Q4	2250	**2002**
11-Q1	2234	**2002**
11-Q2	2576	**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

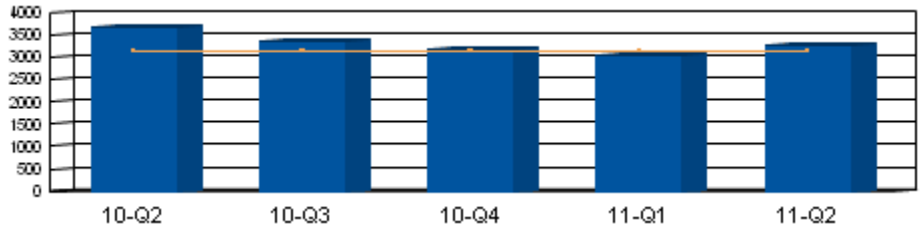
Kingston General Hospital

Milestone #13

SD4 Increase our focus on complex-acute and specialty care

100% of Target service volumes are met

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



	Actual	Target
10-Q2	3691	**3138**
10-Q3	3351	**3138**
10-Q4	3175	**3138**
11-Q1	3058	**3138**
11-Q2	3250	**3138**

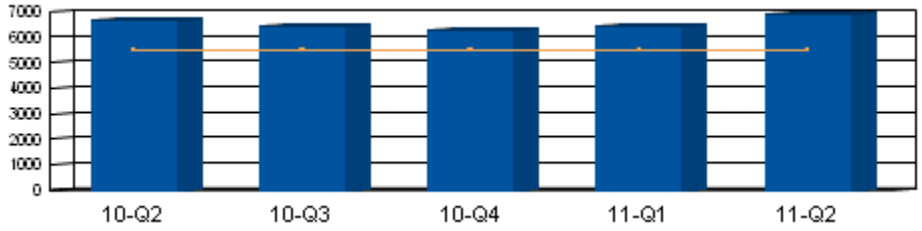
Interpretation - Patient And Business:

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-Q2	6691	**5481**
10-Q3	6421	**5481**
10-Q4	6243	**5481**
11-Q1	6398	**5481**
11-Q2	6936	**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

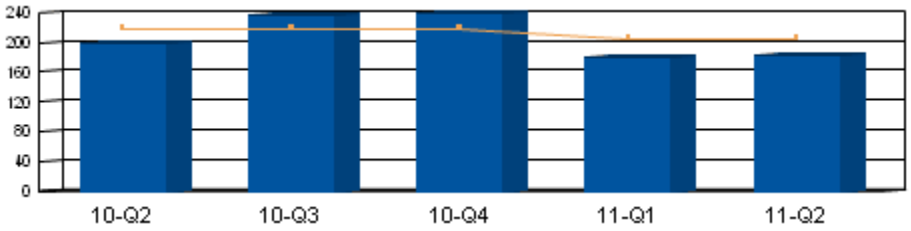
Kingston General Hospital

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-Q2	199	219
10-Q3	238	219
10-Q4	239	219
11-Q1	180	205
11-Q2	183	205

Interpretation - Patient And Business:

As a result of environmental challenges (6 code browns, high humidity OR levels, flooding) as well as the staffing resource issues during the summer period, delays and unpredictable OR cancellations contributed to the inability to meet volumes for this quarter.

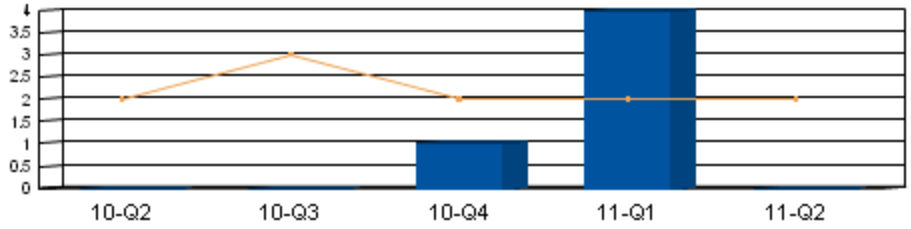
Actions & Monitoring Underway to Improve Performance:

Monthly meeting with program and service leaders from both sites continue to occur in an attempt to strategize on meeting target numbers. As the numbers of uncompleted case volumes continue to climb, challenges exist in the ability to meet the target volumes within the remaining time frame. Plans to review patient booking lists, designation of a complete joint replacement OR room, using weekend ortho operating room hours are all underway to address the situation.

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

Interpretation - Patient And Business:

No transplants were undertaken in the quarter due to no appropriate donor and recipient match.
As can be seen from previous quarters such variation in activity is not unexpected.

Actions & Monitoring Underway to Improve Performance:

Organ donation and transplantation committee has been reformed. Promoting the maximizing of donation.
A task group is being established to review Renal Transplantation (including living donor transplantation).

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

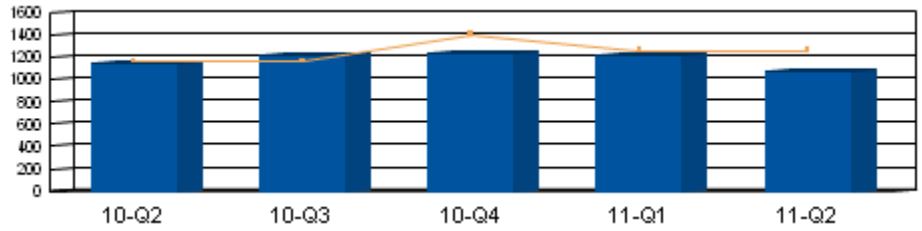
Kingston General Hospital

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-Q2	1155	**1165**
10-Q3	1225	**1165**
10-Q4	1232	**1405**
11-Q1	1212	**1259**
11-Q2	1071	**1259**

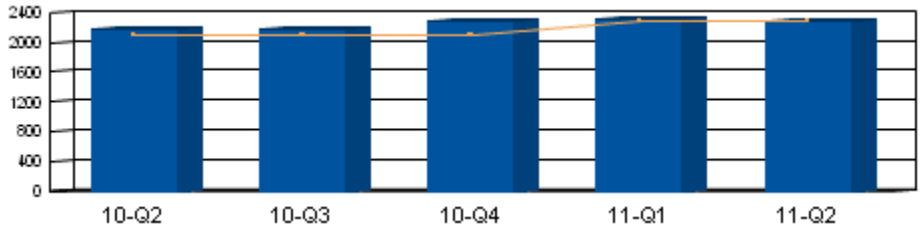
Interpretation - Patient And Business:

We have additional hours this year. KGH is now striving to achieve 5035 MRI hours. We fell behind in Q2 due to summer vacation and due to the fact that we were orientating a new employee. Q3 and Q4 will focus on achieving the total number of hours. This should be achievable providing no unexpected absences, or equipment down times.

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-Q2	2171	**2098**
10-Q3	2175	**2098**
10-Q4	2296	**2098**
11-Q1	2318	**2286**
11-Q2	2274	**2286**

Interpretation - Patient And Business:

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

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: 9145

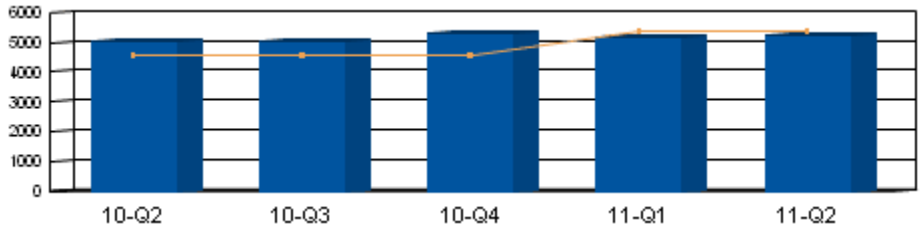
Kingston General Hospital

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-Q2	5050	**4537**
10-Q3	5042	**4537**
10-Q4	5279	**4537**
11-Q1	5191	**5345**
11-Q2	5233	**5345**

Interpretation - Patient And Business:

This indicator has a" green status" for the second time this year even though environmental challenges (6 code browns, high OR humidity, flooding) in this quarter have had a significant impact on operating time.

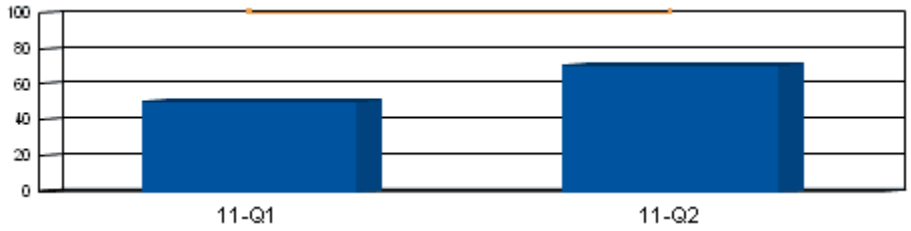
Actions & Monitoring Underway to Improve Performance:

OR hours are closely monitored and with additional evening and weekend operating room time now available it is anticipated these volumes will meet the expected target 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: 21378

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
11-Q1	50	**100**
11-Q2	70	**100**

Interpretation - Patient And Business:

As of Q2, there were 5 incremental volume contracts that were not on target (total joint replacements, intestinal and ventral hernia general surgery, scoliosis repair, and MRI hours). Every effort is being made to maximize Hotel Dieu Hospital capacity where possible. At the recent SE LHIN volume allocation meeting, the KGH released its 35 incremental total joints (13 to the HDH and 22 to the SE LHIN) in recognition of the fact that total joint volumes can not be meet by year end. This is mainly to do with the availability of Orthopedic and Anaesthetic medical person power. Not achieving volume targets by year end poses the risk of these volumes being adjusted downward and permanently reassigned to other hospitals. This carries a financial risk to the organization.

Actions & Monitoring Underway to Improve Performance:

The Wait List Management Committee and the Surgical Program are closely monitoring these issues. 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.

For F2012: Intestinal IP, Groin Hernia, Ventral Hernia,Oral Maxiofascial (Dental), Scoliosis,MRI, CT,Total Joints, Cancer Surgery, Cardiac

Target: Target 11/12: 100%

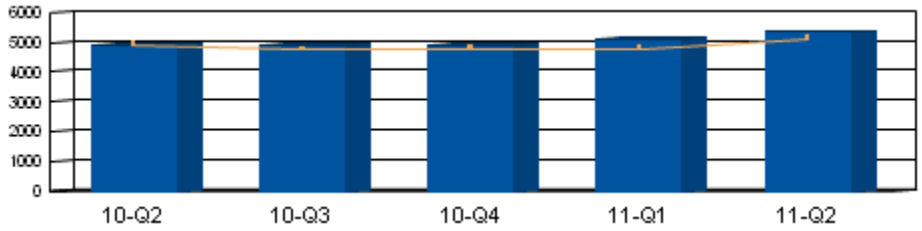
Kingston General Hospital

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-Q2	4912	**4919**
10-Q3	4878	**4779**
10-Q4	4925	**4782**
11-Q1	5082	**4782**
11-Q2	5345	**5125**

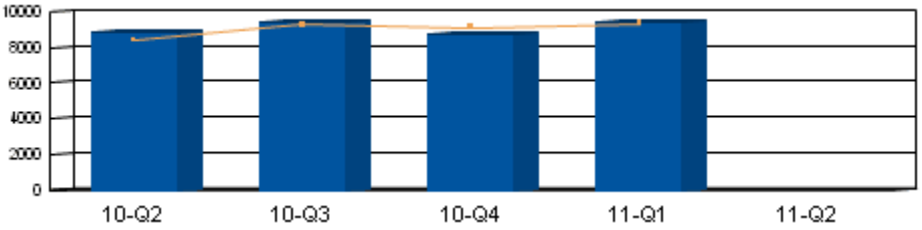
Interpretation - Patient And Business:

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: 20,500

Indicator: Total Inpatient Weighted Cases



	Actual	Target
10-Q2	8877	**8411**
10-Q3	9369	**9284**
10-Q4	8710	**9103**
11-Q1	9363	**9326**
11-Q2		

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

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 (OS)	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   As of Q2, 1 of the six planned areas have achieved implementation. However, there are 3 areas that are in the final stages of implementation and numerous others that are well underway. Development and implementation under the guidance of the Order Set Committee.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Committee oversight for Order Sets has been streamlined to ensure due process has been achieved in design of order sets to ensure best practice. This separation from old terminology and process from preprinted orders has been slow. An Order Set Committee will guide and streamline the process to expedite implementation.

3. **Are we on track to meet the milestone by year end?**
   Yes. If we continue at the current rate of implementation, the target of 6 will easily be achieved or even exceeded.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

   The Order Set Committee will guide the programs in development and process to implement order set throughout most services.

Kingston General Hospital

Milestone #14

				10-Q4	11-Q1	11-Q2
SD4 Increase our focus on complex-acute	KGH clinical staff adopts evidence-based		Number of Clinical Areas that have Implemented Open Source (OS)	N/A	G	R

Indicates worsening performance to target over the past 5 quarters 

Indicates improving performance to target over the past 5 quarters 

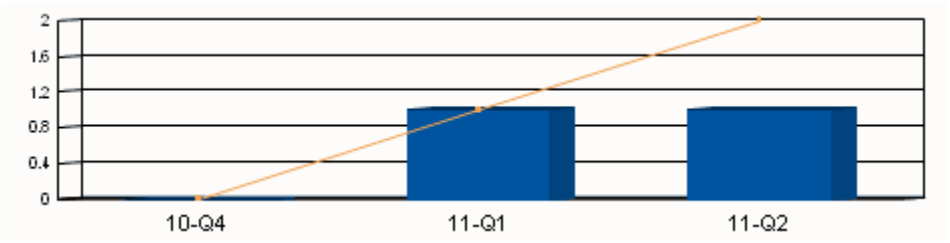
Kingston General Hospital

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	**1**
11-Q2	1	**2**

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:

As of Q2, 1 of the 6 planned areas had achieved Implementation. However, there are 3 areas that are in the final stages of implementation and numerous others that are well underway. Development and implementation continues under the guidance of 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	Red
Average sick days per eligible employee per year	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   While a business plan was completed in the spring; we have been unable to hire or contract a project manager to lead the initiative. The hospital is now going to a RFP process. The rolling average sick days in a 12 months period improved to 10.87, slightly down from Q1 10.90. However, the actual usage in this period were higher than the previous quarter with an increase from 4.3% to 5% (target is 4%) . For all groups the medians and number of incidents remain consistent, however, those who are off are away for longer periods.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The spring decision to recruit for a permanent PM versus exploring both contract and hire approach has delayed the obtainment of a qualified person to lead the Scheduling project. Increased duration of absences, due to surgeries, psychological illnesses and MSI have impacted the indicator for sick days.

3. **Are we on track to meet the milestone by year end?**
   We are not on track for Scheduling and a meeting will occur to ascertain if this initiative should be aligned to the next fiscal year. Related to the sick time indicator, we anticipate that with changes in the collective agreements to the 6th incident of sick pay in a fiscal year, and continued disability management we will achieve target.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   In October, meetings were held to launch a subgroup of the Scheduling project; however, in beginning of November, Staffing/Scheduling department is unable to assign staff. We have continued work on the Attendance Management program and follow-up. We will increase awareness at the unit level via posters and safety boards. There will also be follow-up with targeted departments to ensure compliance with the Attendance Management program.

Kingston General Hospital

Milestone #15

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	R	
			Percent of Overtime Hours	Y	Y	Y	Y	Y	↑
			Percent Sick Time Hours	Y	G	G	Y	Y	↓
			Total Full Time Equivalents (FTE's)	G	Y	Y	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

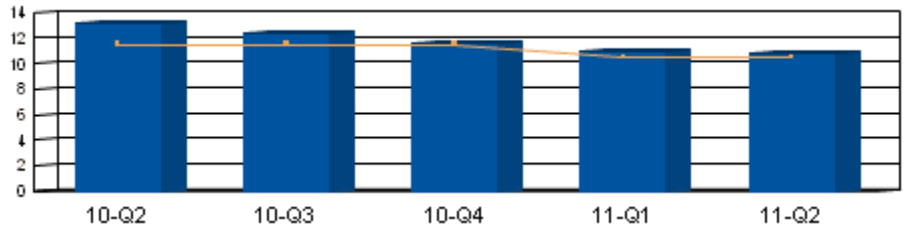
Kingston General Hospital

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-Q2	13.11	**11.5**
10-Q3	12.35	**11.5**
10-Q4	11.62	**11.5**
11-Q1	10.90	**10.5**
11-Q2	10.87	**10.5**

Interpretation - Patient And Business:

The rolling average at the end of September at 10.87 was still down slightly from the previous quarter at 10.90 however, the summer has started to trend upwards again. All groups except non union saw the rolling average increase slightly for but the CUPE group is the most challenging and concerning. CUPE has a rolling average of 13.02 for September, however, the in month statistics are at 1.31. This monthly number is less than August (1.46), but higher than the last two previous Septembers. The end of quarter September overall monthly statistics were 1.08; just slightly more than in August (1.06) and September 2009 and 2010, but higher than would be desired to keep on track. September did not have significant infectious type illnesses but from a disability claims perspective, it appears that there is a number of CUPE staff who are off due to surgery and personal injury. The current top three (3) sources of short term disability are 1. surgical (47%) 2. psychological (31%) 3. musculoskeletal disorders (22%).

This increase in CUPE is partially related to the number of longer term staff who are older (average age is now 46, median is 47) in physically demanding jobs, that have issues such as arthritis, knee and joint issues impacting their ability to remain at work. Portering has an average age greater than 51, and Environmental Services is at 48. These issues are unfortunately longer term in nature, which may impact on the next couple of months due to the duration of total and partial disability.

For all groups, the medians and number of incidents remain consistent and are continuing to hold steady, however those who are off are away for longer periods. When we look at those who are off for four (4) shifts or greater, the numbers have increased back to a level seen one year ago, prior to implementation of the requirement to provide an Attending Practitioner's Statement at day 4, and the changes to process and SAP. In a pay period for example, there may be 86 people off for greater than 3 shifts, whereas, six months ago there were only 60 people off during the pay period for a period of short term disability.

During the quarter on heels of the Collective agreement awards for ONA and OPSEU 444, there was also an award for OPSEU 450 covering the collective agreement from 2009 until 2014. A component of this included a cap on vacation carry over, and similar to ONA and OPSEU 444, a non payment provision for the first 15 hours of the 6th incident of sick time in a fiscal year. This will take effect April 1, 2012 for OPSEU 450. We are only now beginning to see some ONA and OPSEU 444 staff approaching the 6th incident which will reduce their sick pay.

Actions & Monitoring Underway to Improve Performance:

The follow up from managers to OHSW regarding the 4th day of absence of their staff continues to be a loss of opportunity. It is difficult to manage the illness if there isn't any notification regarding the length of time someone is off until after the pay period. After each opportunity that is lost, the manager is reminded and there is now a copy to their director given. Several staff do not receive their pay for the absence in each pay period due to lack of notification and follow up.

Another poster is being developed outlining various departmental/organization unit sick averages and the goal at 10.5. This was a successful method of communicating to staff that could see the progress toward the goal and their own individual departmental statistics.

The disability management policy was revised and submitted for approval that outlines duties and responsibilities of all the parties involved in the return to work process, including employees.

In September, we enlisted a Masters student under the policy pro bono program at Queen's University for public administration and industrial relations students to look at factors contributing to illness and injury and delays in return to work. The term will be from September until March and allow for the collection and analysis of the data (STD, WSIB etc) in relation to other factors such as demographics, types, departments, as well as a component that will evaluate our disability management program. The results will assist us moving forward to get to the next level of information to guide our future practices.

The impact of age may be a factor that emerges since the removal of the age 65 forced retirement barrier. We currently have 3 full time staff in ONA that are 65 or older and 7 in CUPE. We will continue to look at age as a potential factor for ability to remain at work and need to organizationally support greater opportunities for modified work and/or work modifications. It is noted however, that the average age for staff in our attendance program is 42.5. Many staff in their 20s and 30s have significant attendance issues and are driving the program.

Kingston General Hospital

Milestone #15

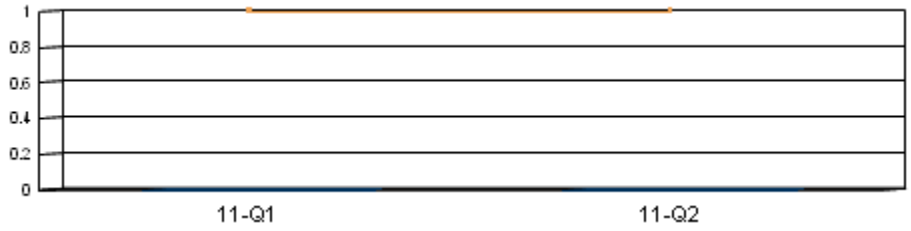
E1 People

Average sick days per KGH employee are reduced to 10.5

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

Indicator: Launch the Staff Scheduling Project



	Actual	Target
11-Q1	0	**1**
11-Q2	0	**1**

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

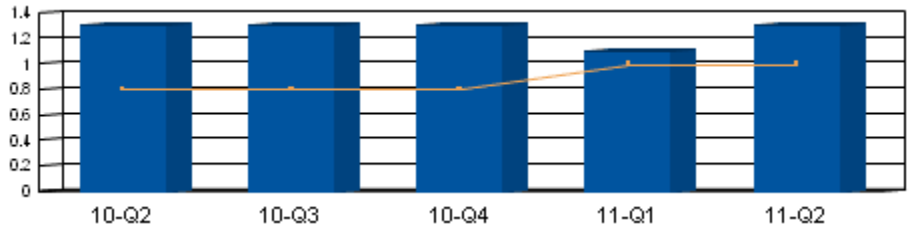
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Percent of Overtime Hours



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

Interpretation - Patient And Business:

Overtime levels were up slightly this quarter. Patient care areas and Maintenance appeared to be the greatest hot spot areas this past summer. Specific areas with variances include Kidd 9, Emergency, Davies 3, Connell 5, Medicine short stay unit, NICU, Pediatrics, Kidd 6, and ICU. Many of the higher areas of overtime have been impacted by sick time, and changes including the mental health move, and the creation of a different make up of units to better align work within the services (short stay unit and C5). New staff in large numbers in Pediatrics and Mental Health has also created extra time required for orientation. Activity and volumes were significantly higher this summer and primarily drove this metric. Visits to Emergency were 342 more than last quarter and 401 more than same period last fiscal year. A surge in Medicine which at times was at 140% occupancy was also impacted by admission rates. 7 short stay medicine beds were opened in July to help decant patients out of the Emergency Department sooner.

Vacation time and scheduling were challenges during this summer period, considered to be 'prime time'. This did not often allow for much surge capacity creating dissatisfaction and staffing issues.

Actions & Monitoring Underway to Improve Performance:

Several initiatives are underway to address the Emergency Department issues and patient flow. Sick time has been reduced, however, with an increase in overtime, it may be impacting time away from work. The summer began to see a slight trending toward higher sick time that is being addressed through many activities related to attendance promotion. Scheduling will have two phases that includes a standardization and review of the current practices, plus the longer term project through ESP to bring the e-systems into new processes, alignment and efficiencies.

The ONA local collective agreement was successfully negotiated and ratified post Q2, which includes provisions for vacation carryover limits, overtime offerings based on status and seniority, and a preference for week blocks of vacation time off during 'prime time' over single days. This will assist with scheduling, satisfaction and staffing during these prime time periods in the future and is a huge step forward for KGH.

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%

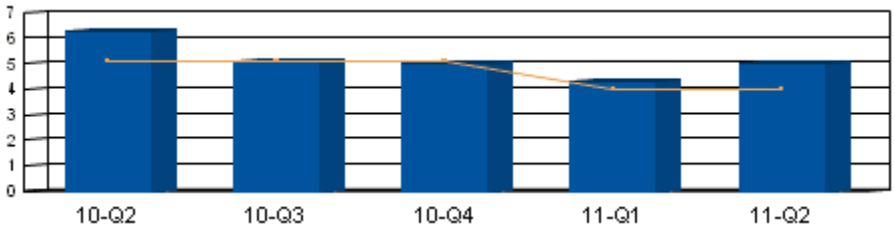
Kingston General Hospital

Milestone #15

E1 People

Average sick days per KGH employee are reduced to 10.5

Indicator: Percent Sick Time Hours



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

Interpretation - Patient And Business:

The end of quarter September overall monthly statistics were 1.08; just slightly more than in August (1.06) and September 2009 and 2010, but higher than would be desired to keep on track. September did not have significant infectious type illnesses but from a disability claims perspective, it appears that there is a number of CUPE staff who are off due to surgery and personal injury. The current top three (3) sources of short term disability are 1. surgical (47%) 2. psychological (31%) 3. musculoskeletal disorders (22%). The types of STD claims cited tend to also be for significant periods of time required to be away from work for recovery,

For all groups, the medians and number of incidents remain consistent and are continuing to hold steady, however those who are off are away for longer periods and hours. When we look at those who are off for four (4) shifts or greater, the numbers have increased back to a level seen one year ago, prior to implementation of the requirement to provide an Attending Practitioner's Statement at day 4, and the changes to process and SAP. In a pay period for example, there may be 86 people off for greater than 3 shifts, whereas, six months ago there were only 60 people off during the pay period for a period of short term disability.

During the quarter on heels of the Collective agreement awards for ONA and OPSEU 444, there was also an award for OPSEU 450 covering the collective agreement from 2009 until 2014. A component of this included a cap on vacation carry over, and similar to ONA and OPSEU 444, a non payment provision for the first 15 hours of the 6th incident of sick time in a fiscal year. This will take effect April 1, 2012 for OPSEU 450. We are only now beginning to see some ONA and OPSEU 444 staff approaching the 6th incident which will reduce their sick pay.

Actions & Monitoring Underway to Improve Performance:

As part of the changes to collective agreements and the reevaluation of the HOODIP plan and criteria, the counting of an incident for the purposes of coding has been brought into alignment with other hospitals and the HOODIP language. We do not yet have this automated in SAP, but are hopeful it will become a priority for Q3 so the reports will more accurately reflect this change. To date, manual tracking of the incidents and numbers has occurred however, the reports are not yet reflecting this interpretation. Once this takes effect in SAP, it may have a slight downward impact on the attendance average as a result. The percent of sick hours however, is being investigated to determine the potential impact of this on the metric.

The follow up from managers to OHSW regarding the 4th day of absence of their staff continues to be a loss of opportunity. It is difficult to manage the illness if there isn't any notification regarding the length of time someone is off until after the pay period. After each opportunity that is lost, the manager is reminded and there is now a copy to their director given. Several staff do not receive their pay for the absence in each pay period due to lack of notification and follow up.

Another poster is being developed outlining various departmental/organization unit sick averages and the goal at 10.5. This was a successful method of communicating to staff that could see the progress toward the goal and their own individual departmental statistics.

The disability management policy was revised and submitted for approval that outlines duties and responsibilities of all the parties involved in the return to work process, including employees.

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%

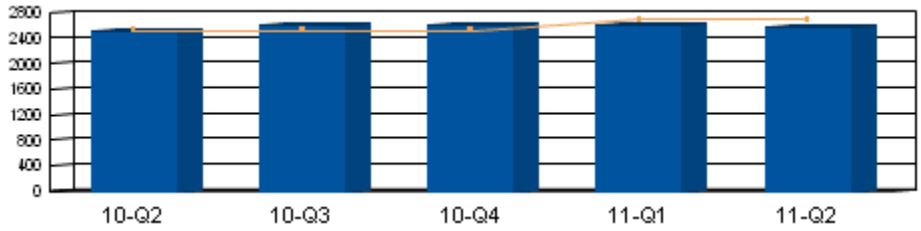
Kingston General Hospital

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-Q2	2511	**2515**
10-Q3	2618	**2515**
10-Q4	2601	**2515**
11-Q1	2613	**2687**
11-Q2	2566	**2687**

Interpretation - Patient And Business:

The FTE count for this quarter is trending downward relative to the target. There were several occasions over the summer months where there was a shortage of staff relative to the amount of patient activity. This resulted in a slight increase in overtime (see indicator). Trending of second quarter indicates a normal reduction in FTEs in the quarter. The downward trend in F2012 is about 3% lower than the prior to second quarters (i.e. Fiscal 2011 and Fiscal 2010).

Actions & Monitoring Underway to Improve Performance:

A complete review of scheduling practices is underway in the clinical areas. This is to ensure collective agreement compliance as well as to ensure adequate baseline scheduling has occurred.

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: 2687

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
Lost Time Injury Claims	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   There has been a significant improvement in the percent of complete of incident investigations from the Q1 percentage of 70% to 86% for Q2. We have also seen a reduction of needlestick injuries from Q1 from 12 to Q2 at 9, only 2 injuries above our target. There has been a considerable increases in musculoskeletal injuries from Q1 at 22, which was one injury below the target of 23, to 38 at end of Q2.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** There has been reminder follow-up with managers after the 4th day after the incident by Occupational Health, Safety and Wellness. There had been a needlestick awareness program in the spring, and specific follow-up by the Safety Advisor on these types of incidents. The factors that increased MSI in Q2 is not yet fully understood and further analysis is underway to assess if correlation with the unusual high level of activity in July in conjunction with reduced staffing that had been planned related to previous year's activity.

3. **Are we on track to meet the milestone by year end?**
   Due to the large amount of MSI in Q2, it is unlikely will receive the target at Q4. However, we are on track to obtain the targets for lost time injury claims, incident investigation and needlestick injuries.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   In October there has been roll-out of Manager training, Safety Talks e-bulletins for managers to share with their teams and obtain sign-off; and departmental focused safety boards. Roll-out of the Workplace Conduct policy and Performance Agreements clearly state the leader's accountability for safety. There has also been reviews of equipment usage such as pharmacy cassettes, lifts, breeze sheets. Focus groups have been conducted with clinical staff to ascertain the barriers to utilize the mobility protocols and causes of MSI. As part of the preparation for the WSIB Workwell Audit in December, a number policies have been created and revised.

Kingston General Hospital

Milestone #16

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

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

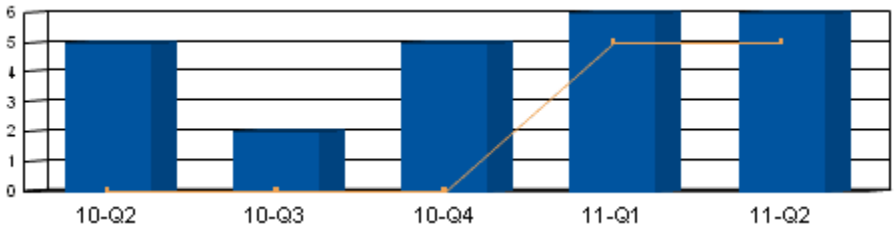
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Lost Time Injury Claims



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

Interpretation - Patient And Business:

Number of LTIs consistent with Q1.
In total, these 6 LTI claims resulted in 15 days of lost time from work.
3 of the MSIs occurred in month of July and 2 of these were related to patient handling.
Causes of the LTIs were as follows: 2 falls, 2 MSIs, and 2 MSIs related to patient handling .
Additional lost time injuries were avoided through the provision of modified work- 13 employees were on modified work during Q2 which equated to a total of 233 modified work days.

Actions & Monitoring Underway to Improve Performance:

Greatest opportunity to prevent LTIs continues to be preventing the injuries in the first place. Through our new "Hazard Recognition, Control & Management Inspection Program," we are intending to shift the focus toward prevention and proactive activities that can be undertaken to eliminate or control hazards in the workplace. Through monthly inspections, leaders will identify and address hazards including work conditions and behaviours. Training on this new program began in October.

In September a new Policy "Disability Management, Return to Work, and Accommodation" was developed and approved. This policy speaks to the requirements of KGH as an employer to provide early & safe return to work, and reinforces obligations of all workplace parties after a workplace injury. In order to familiarize leaders of the policy and their accountabilities related to the provision of suitable work, we will review in upcoming HR Advisor Exchange (November) and in next Leadership Exchange newsletter.

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)

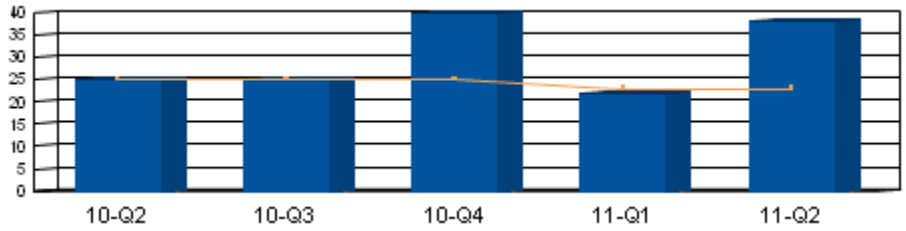
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Musculoskeletal Injuries (MSIs)



	Actual	Target
10-Q2	25	**25**
10-Q3	25	**25**
10-Q4	40	**25**
11-Q1	22	**23**
11-Q2	38	**23**

Interpretation - Patient And Business:

Significant increase in Q2 in reported MSI related incidents. Of the 38 incidents, 63% (N= 24) were related to patient handling activities (lifting, transferring, repositioning), and 37% (N= 14) were due to all other causes (MSI -Other)

MSIs Other- 9 involved the pushing, pulling, or lifting of equipment, 2 were ergonomic related, 2 were musculoskeletal injuries related to patient action, and 1 was due to posture (repetitive bending). The back was the area injured in 50% of the incidents reported. The highest incidence of MSI-Other occurred in Environmental Services (5 incidents).

MSIs- Patient Handling- 60% of these MSIs occurred during patient transfers. The most common area of injury was to the back (60%), then shoulder (25), then hand/arm (15%). Nearly half of the patient handling MSIs occurred in the month of July. Highest incidence of MSIs due to patient handling occurred on Medicine floors (N=7), Surgical floors (N=7), and Davies 4 ICU (N=4)

Actions & Monitoring Underway to Improve Performance:

Due to the large number of MSIs related to patient handling the following actions have or are being taken:

-Discussion at Nursing Practice Council Sept 2011- to identify barriers to full implementation of the Safe Patient Handling Program implemented in Jan 2010. Professional Practice working with PT/OT to evaluate program and to address issues related to taking walkers away from patients when admitted. Focus group- Directors, Program Managers & Clinical Educators of those clinical units with high MSI's invited to participate to identify and address contributing factors to high incidence. A similar focus group is being formed for the non-clinical depts with high MSIs (Environmental Services, Portering, Nutrition, and CPS) .

-Training: Hazard Recognition & Control (Part 1)- began October 12 and is designed to assist leaders in identifying hazards (including behaviours) and controlling them. Monthly workplace inspections will provide the opportunity for leaders to assess and address practices related to patient handling, adequacy of equipment, etc. Hazard Recognition & Control Training (Part 2) for leaders begins October 27 and is intended to improve the knowledge and skill of leaders to perform root cause analysis when injuries do occur. This will assist leaders in understanding and controlling the underlying causes of these MSI's.

-As well, the new management inspection program (rolling out now) will provide the opportunity for improved visibility of safety and opportunity to address MSI and other safety related hazards.

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

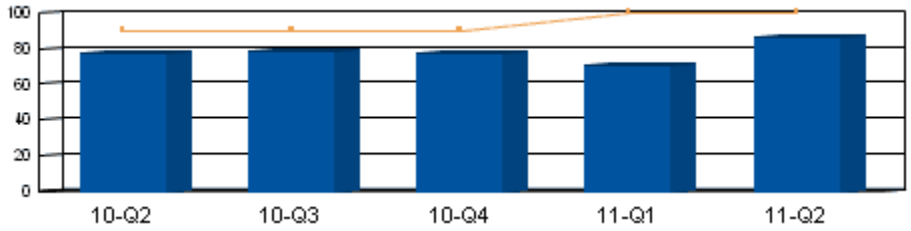
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Percent Completion of Incident Investigations



	Actual	Target
10-Q2	77	**90**
10-Q3	78	**90**
10-Q4	77	**90**
11-Q1	70	**100**
11-Q2	86	**100**

Interpretation - Patient And Business:

Improvement over Q2 in completion of investigations by management with highest completion rate to date (86%). This may be partly attributed to the process put in place by OHSW in the summer where they now send a reminder within the Safe Reporting Tool day 4 after the incident (policy requires they be done within 3 business days) to those who have not yet completed. Along with this reminder, templates and instructions to assist the Manager/Supervisor are now attached within the incident itself for easy access.

Actions & Monitoring Underway to Improve Performance:

To address recurring incidents and reduce our incidence of workplace injury, lost time, and associated costs, it is critical that as an organization we ensure corrective actions are being implemented to address incidents/injuries are effectively controlling the actual cause(s) of the incident. To strengthen leaders' knowledge & skill in conducting investigations and root cause analysis, "Hazard Recognition & Control" training is being rolled out by OHSW to all leaders as of Oct 28/11.

Accountability is further being enhanced via role out of the performance agreements for KGH managers during September and October and the Workplace Conduct policy during October and November to the KGH Leadership Group via the one-day mandatory leadership development day.

Incident Investigation continues to be part of the quarterly reporting process for Directors to report on by program

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

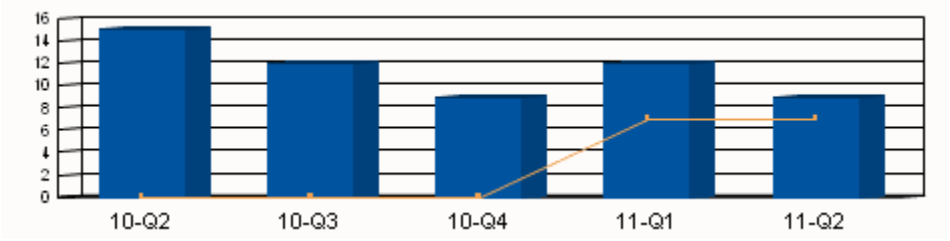
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Reduction in Needle Stick Injuries



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

Interpretation - Patient And Business:

Some overall improvement in the incidence of Needlestick injuries (NSIs). Devices involved in the 9 NSIs in Q2 were as follows:

Non-safety blood gas needle (1), suture needle (2), insulin safety needle (1), safety butterfly (2) used for venipuncture, non-safety hypodermic needle (1), safety hypodermic needle (1), blunt fill needle (1).

While 2 of the incidents were related to patient action (ie. the patient flinched, or bumped HCW's arm), the remaining were due to technique and/or failure to activate the safety mechanism on the needle immediately after use. As well, 2 of the needles used were non-safety engineered. It is a requirement of the Needle Safety Regulation that hollow bore needles used by safety engineered.

30 % of the incidents (N= 3) occurred on one unit (Kidd 3).

Actions & Monitoring Underway to Improve Performance:

Thorough investigation of NSIs is essential in order to understand the true causes so that appropriate controls/corrections can be implemented. In 2 of the NSIs safety engineered devices were not used- understanding why and addressing this is imperative.

To develop the knowledge & skill of our leaders to conduct investigations and root cause analysis, "Hazard Recognition & Control" training (Part 2) is being rolled out by OHS to all leaders as of Oct 28/11.

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 needlstick 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 occuaptional disease claims.

Target: Target 11/12: 26

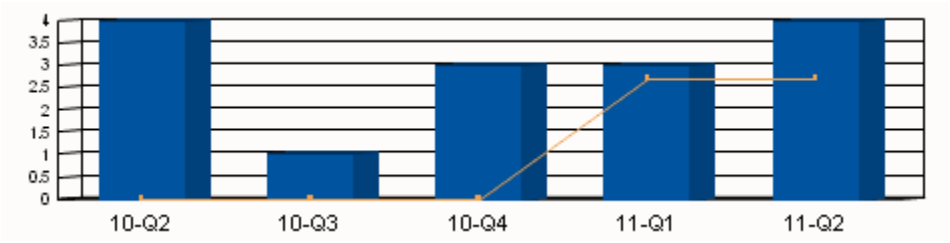
Kingston General Hospital

Milestone #16

E1 People

Lost time injury claims are reduced by 10%

Indicator: Reduction in Time Lost Injury Claims Due to Musculoskeletal Injuries



	Actual	Target
10-Q2	4	
10-Q3	1	
10-Q4	3	
11-Q1	3	**2.7**
11-Q2	4	**2.7**

Interpretation - Patient And Business:

With high incidence of overall MSIs this quarter (N=38), we saw our LTIs due to MSI increase up to 4. Two (2) of these were patient handling related that occurred in July and 2 were MSI-other. One of the MSI-others resulted in over a week of lost time and a requirement for continued modified duties since early September. This incident has not yet been investigated.

Actions & Monitoring Underway to Improve Performance:

To develop the knowledge & skill of our leaders to conduct investigations and root cause analysis, "Hazard Recognition & Control" training (Part 2) is being rolled out by OHS to all leaders as of Oct 28/11.

2 focus groups (clinical and non-clinical) are being formed to review strategies by which we can improve our existing MSI prevention programs and ensure compliance with program expectations.

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

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	**Yellow**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   There has been a significant improvement in mandatory training with an overall 88.4 % of completions.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Managers have been getting regular reports and HR X-Changes and Leadership Exchange e-bulletins to managers have emphasized the requirement to get these completed. Additionally, Directors report quarterly to their supervisor regarding the completions within their portfolios.

3. **Are we on track to meet the milestone by year end?**
   At the end of Q2 we anticipate we will achieve the 100% it, but the current approach is not sustainable. The Learning Management System is not full rolled out as the implementation was delayed due to vendor support and there is no coordinated corporate approach to enable staff to take mandatory training.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The Learning Management System will be upgraded by end of November 2011. There is a sustainment plan under development to pilot out a different approach to enable staff to keep up-to-date. This entails staff being scheduled into refresh update sessions. Pilot under development that includes roll-out of the Workplace Conduct policy and combination of online and face-to-face modalities – require commitment of one FTE to complete curriculum design in December-January, with pilot in February - April.

Kingston General Hospital

Milestone #17

				10-Q4	11-Q1	11-Q2
E1 People	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	R	Y

Indicates worsening performance to target over the past 5 quarters 

Indicates improving performance to target over the past 5 quarters 

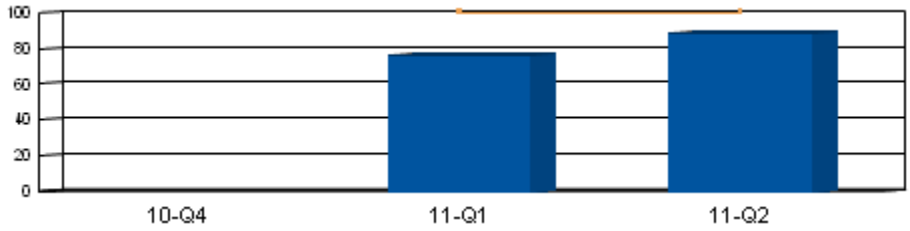
Kingston General Hospital

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**
11-Q2	88.4	**100**

Interpretation - Patient And Business:

Steady improvements in mandatory training have occurred currently sitting at:

MSI	96.67%
WHMIS	87.75%
Workplace Violence	86.84%

The LMS improvement project is underway which will improve the ability to track and send information on some of these training elements that does not currently exist.

Actions & Monitoring Underway to Improve Performance:

All training topics are now woven into the orientation expectation to be done within first 2 weeks of hire. New hires receive as 'training advisory' to also remind them of this however the bulk of the ones outstanding are the new hires. An August 2 deadline was set as a push toward completion. The leaders have been reminded of the requirements and regular reports are sent to obtain the status of their group. It will be woven into the leaders safety training and performance agreements with a special focus on residents in the upcoming quarter.

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%

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	**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The target for the KGH Leadership Group is 100% compliance in attendance at process improvement session. However, the curriculum has not been defined and dates have not been set.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   There was a focus on other training for KGH Leadership Group for the fall Leadership Days that were conducted. Additionally, there is not an implementation plan to enhance Process Excellence is not in place

3. **Are we on track to meet the milestone by year end?**
   At the end of Q2, we are not on track to reach the milestone.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   There are meetings scheduled in November to commence discussions and define further the curriculum and required dates. It is also recommended that this milestone be moved to the first quarter in Fiscal 2013 due to the capacity of managers to complete the training and ensure that usage of the training occurs with specific deliverables.

Kingston General Hospital

Milestone #18

				11-Q1	11-Q2
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	Y	R

Indicates worsening performance to target over the past 5 quarters 

Indicates improving performance to target over the past 5 quarters 

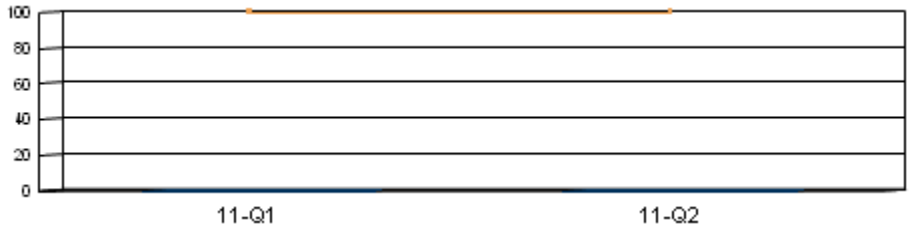
Kingston General Hospital

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**
11-Q2	0	**100**

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 complete 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
Redevelopment (Space for New Clinical, Retail, Nutrition Facilities)	Green
Phase 1 Redevelopment is Completed on Time and on Budget	Green
Phase 2 Redevelopment Planning Started	Yellow

1. **What is our actual performance on each of the indicators for this milestone as listed above?** Phase 1 has achieved 96.1 % completion at Q2; ahead of the original schedule. (at 97.2% as at October 31, 2011). The projected substantial completion date is December 22, 2011. The new retail and food services are on target to open in Q4. Tim Hortons in the Abramsky lobby is opening in January 2012 and the new Steamplicity inpatient food services will complete roll out in February 2012. Cafeteria renovations to be completed by February 2012. Phase 2, selection of the consultants to prepare the documents for Step 1 of the Ministry Capital Process in progress.
2. **What are the contributing factors to the current performance of the indicators for this milestone?** Key to the success of Phase 1 has been ongoing monitoring and oversight of the project as outlined below to ensure any decisions or issues are addressed in a timely fashion. Retail and food services success has only been possible as a result of continued efforts to obtain necessary Ministry approvals to allow construction to be completed in time to open the services in this fiscal year. Phase 2 progress continues due to support obtained from the Ministry to support Step 1 work continuing to prepare for submission in fiscal 2013.
3. **Are we on track to meet the milestone by year end?**
   As noted above, we are on track to meet the milestone by March 31, 2011.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** In addition to the project teams that are meeting regularly to review and resolve any issues; the progress on each of these projects is also being closely monitored by Joint Planning Office, the Redevelopment Sub-Committee of Resource Committee, Joint Building Committee (representatives of Infrastructure Ontario, JPO, Prime Consultants, KGH) and the Operations Committee.

Kingston General Hospital

Milestone #19

				10-Q4	11-Q1	11-Q2
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	G
			Phase 2 Redevelopment Planning Started	N/A	G	Y
			Redevelopment (Space for new Clinical, Retail, Nutrition Facilities)	N/A	G	G

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

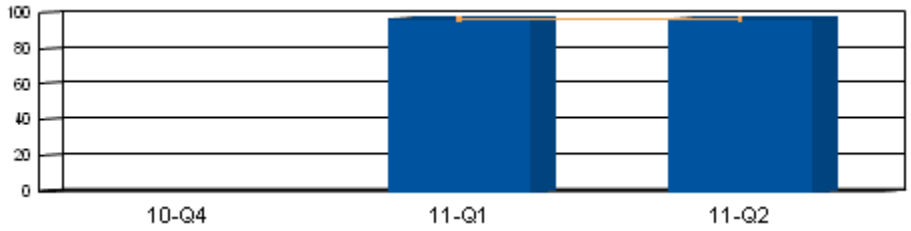
Kingston General Hospital

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
11-Q2	96.8	96

Interpretation - Patient And Business:

On time and on budget the project is 96.8 per cent complete to date.

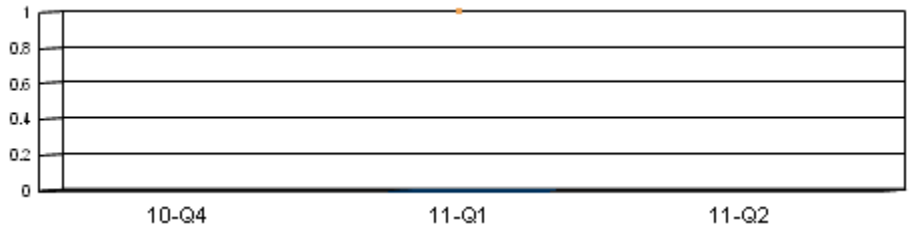
Actions & Monitoring Underway to Improve Performance:

Project team continues to monitor the project to ensure that it remains on schedule and budget.

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

Target: Target 11/12: 96%

Indicator: Phase 2 Redevelopment Planning Started



	Actual	Target
10-Q4		
11-Q1	0	1
11-Q2		

Interpretation - Patient And Business:

Step 1 of the planning grant process is underway.

Actions & Monitoring Underway to Improve Performance:

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

Target: Target 11/12: Yes

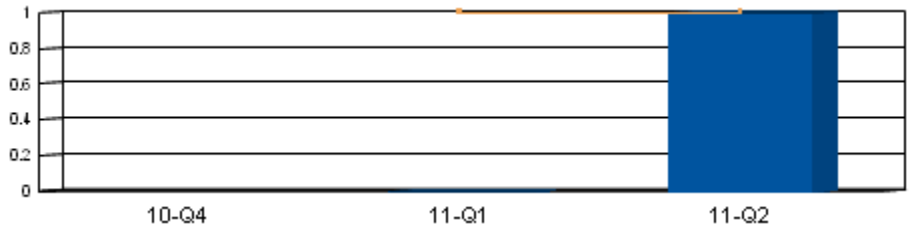
Kingston General Hospital

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**
11-Q2	1	**1**

Interpretation - Patient And Business:

Actions & Monitoring Underway to Improve Performance:

To continue to monitor the projects to ensure that they remain on target

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

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	Red

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The carpet project schedule has had to be refined due to capacity to move inpatient units and our projection now is that 40% of the carpet project will be completed by March 31, 2012, 77% by March 2013, and 100% by September 2013. The Solar project remains yellow and on hold at September as a result of unknowns created by the Ontario Provincial Election. We still await the approval for our application to Ontario Power Authority. In late October a review of rates of solar energy reimbursement was announced by the Province and once this information is available our business case for the project will be reviewed to determine if we can continue.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Solar project on hold as noted above. The new time line for the carpet removal is due to our limited capacity to relocate clinical units during the transition to enable construction. We only have the capacity to do one inpatient unit at a time due to limited decanting space for inpatient services. Early time estimates had to be refined once tenders were completed.

3. **Are we on track to meet the milestone by year end?** The solar project due to the Election and the review of Provincial rates will definitely delay the end point into 2013 fiscal. If new reimbursement rates are approved, the business case will need review to ensure it is still sound. 40 Percent of carpet removal is expected by March 31, 2012.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** We continue to monitor the solar project and are prepared to respond as soon as Provincial Review is completed. Carpet removal is overseen by both the JPO and Clinical Leadership and regularly reported to the Operations Committee for monitoring.

Kingston General Hospital

Milestone #20

				10-Q4	11-Q1	11-Q2
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	G
			Solar Farm Established		Y	R

Indicates worsening performance to target over the past 5 quarters

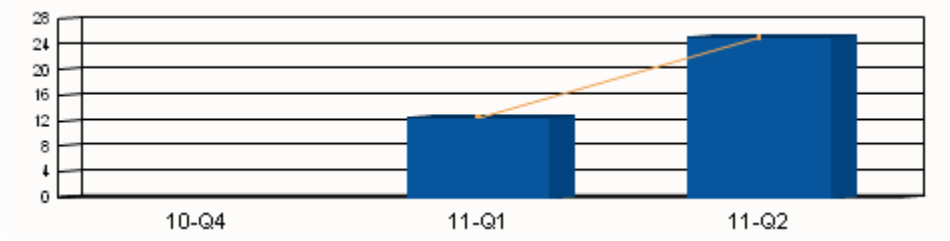
Indicates improving performance to target over the past 5 quarters

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	**12.5**
11-Q2	25	**25**

Interpretation - Patient And Business:

40% of carpet removal is expected by March 31, 2012.

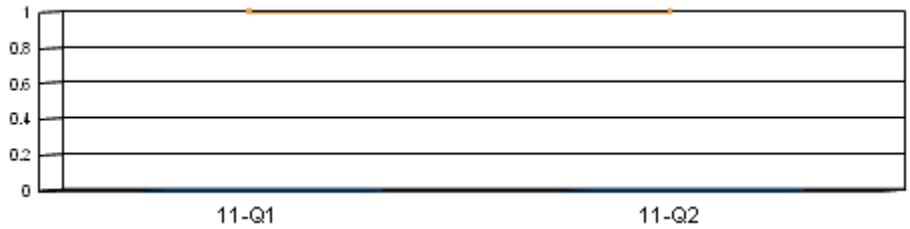
Actions & Monitoring Underway to Improve Performance:

40% of carpet removal is expected by March 31, 2012.

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**
11-Q2	0	**1**

Interpretation - Patient And Business:

Project is pending approval from the Ontario Power Authority. Substantial delays in the approval process have pushed this initiative into next fiscal year. Approval expected before the end of the calendar year. Once approved detailed engineering may proceed. If approved, installation expected to be complete Q2 2013.

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

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		**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Our goal was to have 50% of the medication carts in operation by March 31, 2012. This plan timeline will be re-evaluated as we currently are still in the procurement process to select a vendor for the dispensing system. Product selection is expected early in the new calendar year and implementation will now be delayed until 2012/13 and is expected to take us into 2013/14. Actual delivery and live dates will be confirmed in the contract negotiations.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The major contributor to this result has been our under estimation of the time required for the new procurement guidelines to be followed; the capacity of 3SO to manage the remaining on boarding hospitals; as well as our increased demand from hospitals for procurement services to support new initiatives.

3. **Are we on track to meet the milestone by year end?**
   No – this initiative will need to resubmit a revised time line for review and approval. To do this accurately, we will need to complete the RFP process before new estimates are created. New time lines should be set by the end of Q3.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Given the above realities the KGH Selection Committee for the Medication Carts is working with 3SO to advance the procurement process and senior leadership of both organizations have been engaged to support.

Kingston General Hospital

Milestone #21

				11-Q1	11-Q2
E4 Technology	50% of our automated medication dispensing system is in place		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	G	R

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

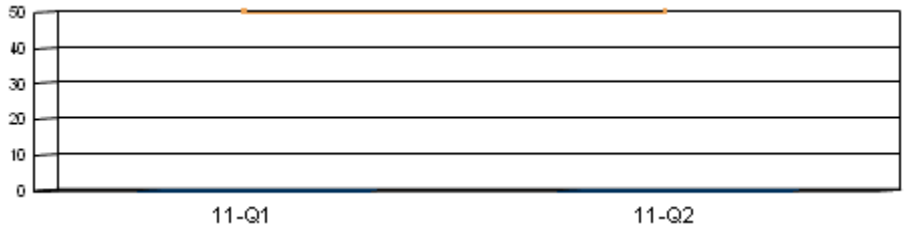
Kingston General Hospital

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**
11-Q2	0	**50**

Interpretation - Patient And Business:

3 shortlisted vendors presented to the selection team in August. 3SO tasked with reference checks, and comparing vendor equipment storage capability.
Meeting in October: Reference checks for installs from 2000 - 2002 range, plus comparison not fully completed. Team determined that 3SO required to obtain reference from installs much more recently, plus complete comparison data.

3SO requested to start setting up site visits with the 3 vendors, plus team determined selection date of mid-December is the target.

Situation discussed with Jim Flett, COO as concerned that target will likely not be met.

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 order and DI management system is 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		**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   As at Q2 planning, capital acquisitions, and preparation of stakeholders for the change in process has begun, including a beta trial in the ICU to test the tools. Implementation across the hospital is expected to phase in between December and March 2012.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   One of the largest challenges has been the hiring of a project manager. The project was just successful in recruiting a project manager at the start of Q3. This has limited some of the capacity to advance the project earlier, but the efforts of line managers has continued the preparations.

3. **Are we on track to meet the milestone by year end?**
   It is important to note that as per the Q1 report, a phased approach was adopted with labs slated for this year and diagnostic for next. An updated implementation plan is expected by November 11 and at present we anticipate a March 31, 2012 time line is still possible.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   The main reason the time line is reachable is that staff continued to prepare the plans, equipment and systems for implementation during the recruitment phase of the project manager. The beta testing has also allowed for interaction between laboratory and nursing staff, as well as other stakeholders (IT etc.) to better understand the opportunities and challenges in these process changes.

   There will of course be a review at the end of Q3 as to our progress and any new information will be included in that update.

Kingston General Hospital

Milestone #22

				11-Q1	11-Q2
E4 Technology	Our lab and diagnostic imaging order management system		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	G	R

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

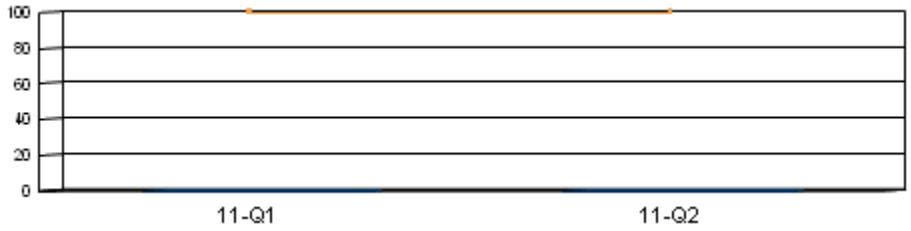
Kingston General Hospital

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**
11-Q2	0	**100**

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%

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	**Red**

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Our target is 80%, and at the end of Q2 we had achieved 29%. This performance is virtually unchanged from Q1 (30%).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The completion within 72 hours is highly aligned with the number of discharges completed by e discharge. Our efforts are therefore focused on moving clinicians to utilizing the e-discharge. Adoption of e-discharge is not occurring as quickly as we had anticipated.

3. **Are we on track to meet the milestone by year end?**
   We are not on track at present to meet this milestone and work is underway to find mechanisms to encourage further adoption of the e-discharge tool by clinicians.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Health Information Services has in Q3 implemented a process to improve notification to physicians of incomplete charts, monitoring of compliance and corrective actions to achieve target. The following initiatives are also being introduced:
   1. Health Information Services will in Q3 provide real-time chart deficiency status to the physicians. This represents a substantial improvement compared to the existing manual system which only notifies the physician when the 72 hour target is exceeded.
   2. Information Management will revisit departments and services with low use of the e-discharge application to encourage adoption. It is important to note that 93% of all discharges completed with the 72 hour target are done so with the use of the e-discharge application.

Kingston General Hospital

Milestone #23

				10-Q4	11-Q1	11-Q2
E4 Technology	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	R	R

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

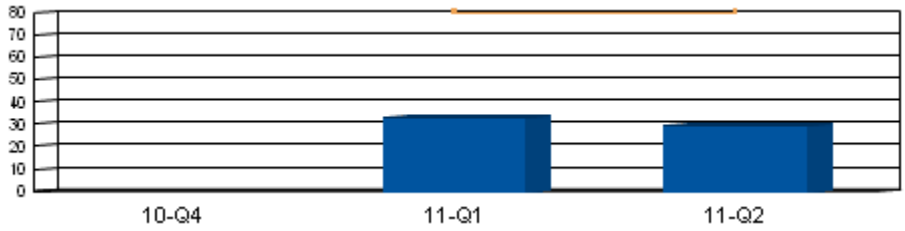
Kingston General Hospital

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**
11-Q2	29	**80**

Interpretation - Patient And Business:

Despite overall chart deficiencies continuing to trend downward, approximately 30% are completed within the 72 hour target. This represents a slight decrease from the first quarter. Health Information Services implemented the manual processes to improve notification to physicians of incomplete charts, monitoring of compliance and corrective actions to achieve target levels with minor revisions approved by the Patient Records Committee in September. Information packages on the new process were sent to all attending physicians and full implementation of the manual processes are now in place.

Actions & Monitoring Underway to Improve Performance:

Efforts to improve this indicator will focus on the following initiatives being introduced to improve compliance:

1. Health Information Services is continuing its efforts to develop and implement an electronic system that will provide real-time chart deficiency status to the physicians. This represents a substantial improvement compared to the existing manual system which only notifies the physician when the 72 hour target is exceeded.

2. Information Management will revisit departments and services with low use of the e-discharge application to encourage adoption. It is important to note that 93% of all discharges completed with the 72 hour target are done so with the use of the e-discharge application.

3. Health Information Services with the support of Medical Administration continues to monitor compliance and impose sanctions 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%

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 is our actual performance on each of the indicators for this milestone as listed above?** As at Q2 we are running an actual operating surplus ($ 2.5 million) and we have currently allocated $10.7 million for capital spending for 2011/12.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Our positive financial results reflect: new post construction operating funding, continuing drawdown on our vacation liability, and positive performance on various revenue and recovery sources. The capital allocation remained relatively unchanged in the second quarter.

3. **Are we on track to meet the milestone by year end?**
We are expecting to achieve this milestone by March 31, 2012. The projected year end operating position is a slight surplus and efforts continue to see opportunity to expand the capital spending opportunities towards the goal of $12 million. As of October 31, 2012 due to Post Construction Operating Plan funding our year end projection is now at $11.4 million for capital spend, and work continues to look for more sources of capital funding.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** In addition to quarterly performance reviews, the KGH approach to fiscal management also includes ongoing monthly review and monitoring of budget to actual performance. Overall corporate performance is also reviewed at the Operations Committee, Executive Management and the Resource Committee of the Board. To help support increasing our capital spend capacity we will be looking for ongoing efficiencies to shift to capital as we commence our 2012/13 budget process over the next few months.

Kingston General Hospital

Milestone #24

			10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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 ($000's)			Y	Y	Y	↑
		Total Margin	G	G	G	G	G	↑
		Working Capital ($000's)	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

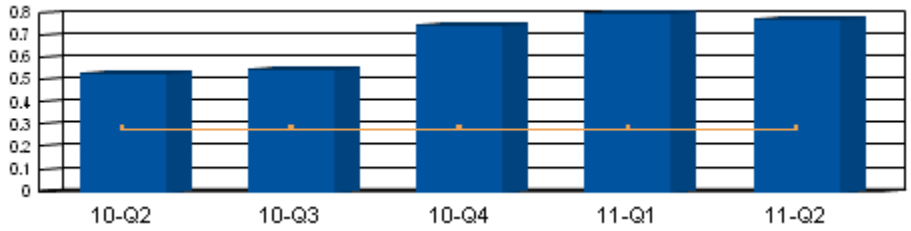
Kingston General Hospital

Milestone #24

E5 Finances

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

Indicator: Current Ratio



	Actual	Target
10-Q2	0.53	**0.28**
10-Q3	0.55	**0.28**
10-Q4	0.74	**0.28**
11-Q1	0.80	**0.28**
11-Q2	0.77	**0.28**

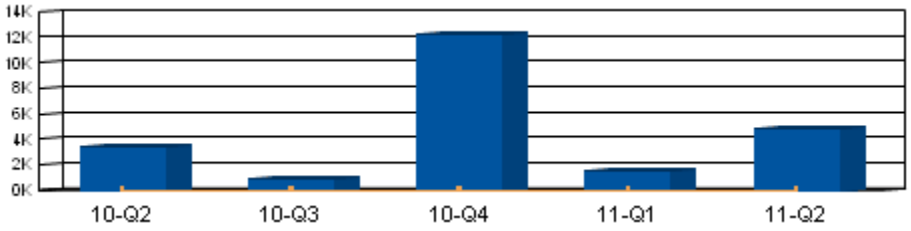
Interpretation - Patient And Business:

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-Q2	3358	
10-Q3	868	
10-Q4	12265	
11-Q1	1528	
11-Q2	4875	

Interpretation - Patient And Business:

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

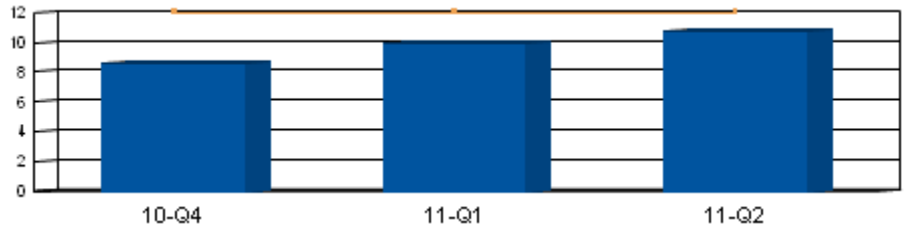
Kingston General Hospital

Milestone #24

E5 Finances

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

Indicator: Total Dollars for Capital Equipment ($000's)



	Actual	Target
10-Q4	8.568	**12**
11-Q1	10	**12**
11-Q2	10.7	**12**

Interpretation - Patient And Business:

The total dollars available for capital investment will support the replacement of clinical, non-clinical and information management technology.

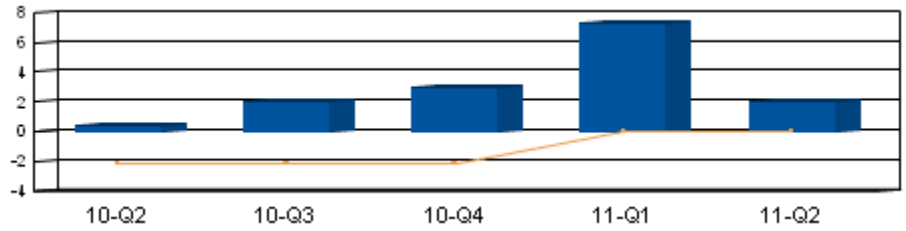
Actions & Monitoring Underway to Improve Performance:

The hospital currently has the capacity to provide $10.7M 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-Q2	0.47	**-2.17**
10-Q3	2.08	**-2.17**
10-Q4	2.95	**-2.17**
11-Q1	7.32	
11-Q2	2.01	

Interpretation - Patient And Business:

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

Definition: Operating margin "measures total operating revenues in excess of total expenses". It is a measurement 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

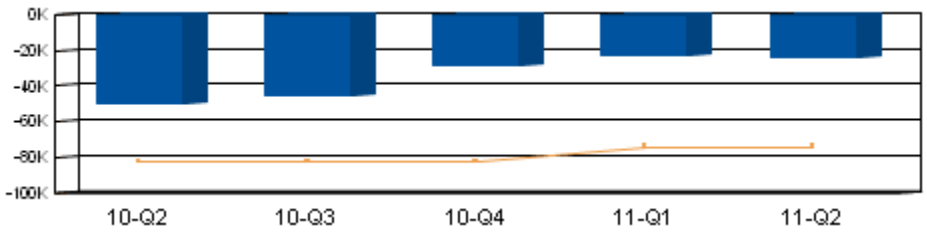
Kingston General Hospital

Milestone #24

E5 Finances

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

Indicator: Working Capital ($000's)



	Actual	Target
10-Q2	-49498	**-82352**
10-Q3	-45150	**-82352**
10-Q4	-28451	**-82352**
11-Q1	-22214	**-74000**
11-Q2	-23560	**-74000**

Interpretation - Patient And Business:

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

Strategic Direction	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 is our actual performance on each of the indicators for this milestone as listed above?**
   KGH Connect, a new web-based platform to engage regularly with stakeholders using social media platforms (YouTube, Facebook and Twitter) is in development and on schedule t o be launched in Q3.A new quarterly reporting format (KGH This Quarter and accompanying video blog of CEO) has been successfully launched online. A communications strategy and plan for FOI legislation was completed in Q2 and is now being implemented .

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Two key roles (Communications Specialist, Web & New Media and Communications Specialist) have been filled and will support these new initiatives.

3. **Are we on track to meet the milestone by year end?**
   Yes. Our goal is a to develop a credible, evidence-based, effective internal and external communications strategy that ensures alignment of communication tools, processes and content with stakeholders' needs and preferences.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   A comprehensive review of the KGH website has begun. A web strategy in conjunction with IM, will identify areas for improvements for all online internal and external communications. The goal is to find ways in which social media platforms can be used for on-going engagement and interaction with KGH stakeholders

Kingston General Hospital

Milestone #25

				11-Q1	11-Q2
E6 Communication	Patient, staff, and stakeholder engagement takes		Implementation of Improved Website and Social Media Tools	G	G

Indicates worsening performance to target over the past 5 quarters 

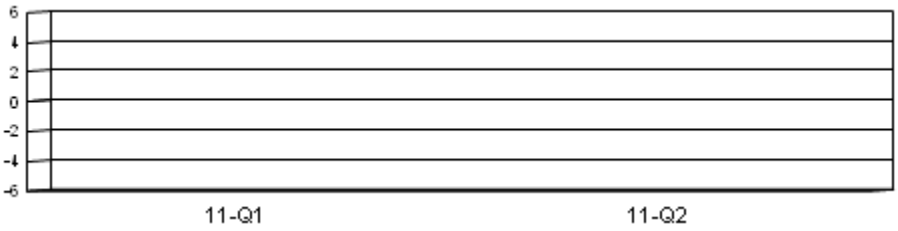
Indicates improving performance to target over the past 5 quarters 

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		
11-Q2	N/A	

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)

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	Y	R	N/A	N/A	↓
	70% of our people who are surveyed rate us as		Hospital Standardized Mortality Ratio (HSMR)	R	G	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	R	↓
			MRSA (Methicillin-resistant Staphylococcus aureus)	R	R	Y	Y	Y	↓
			Number of New Cases of Hospital Acquired Infection	G	R	R	G	Y	↑
			Surgical Site Infection (SSI) Prevention	Y	Y	Y	Y	Y	↑
			Ventilator Associated Pneumonia	G	G	G	G	G	↑
			VRE (Vancomycin-resistant Enterococcus)	Y	Y	G	Y	Y	↑
	We achieve 100% hand hygiene compliance across		Hand Hygiene Compliance	Y	Y	G	Y	Y	↓
	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	G	G	R	R	↑
			Overall - Acute Average Length of Stay Days (Based on HSAA)	R	Y	Y	Y	N/A	↑

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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)	G	G	G	G	N/A	↑
			Percent ALC Days	R	R	R	Y	N/A	↑
			Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↑
			Readmission rate Within 30 Days for Selected CMG's	G	R	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)	R	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	G	G	G	G	↑
			Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	R	R	G	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	R	↑
			Radiation Wait time (Referral-Consult) Percent seen within 14 days	G	G	G	G	R	↓

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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)	Y	R	R	G	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)	Y	Y	R	G	G	↑
			Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	Y	R	R	R	↓
			Percent of Patients Admitted (from the Emergency Department) within a wait time target of <8 hrs	Y	Y	Y	G	Y	↑
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	Y	Y	G	G	G	↓
			New Clinical Trials	G	G	G	G	R	↓
			Percent Increase of Externally Funded Research Dollars at KGH				N/A	G	
SD4 Increase our focus on complex-acute and specialty care	100% of Target service volumes are met		Stem Cell Transplants	G	Y	G	G	G	↑
			Ambulatory Care Volumes	G	G	G	G	G	↑
			Cardiac - Angiography Volumes	G	G	G	G	G	↑
			Cardiac - Angioplasty Volumes	G	G	G	G	G	↑
			Cardiac - Bypass Volumes	G	G	G	G	G	↓
			Chronic Kidney Disease Program- Weighted Units	G	G	G	G	G	↑

			10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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)	Y	G	G	Y	Y	↓
		Kidney Transplants	Y	Y	Y	G	G	↑
		MRI Hours (Wait Time Strategy Allocation)	G	G	R	G	Y	↓
		OR Cases (Inpatient and Outpatient))	G	G	G	G	G	↑
		OR Hours (Inpatient & Outpatient)	Y	Y	Y	G	G	↑
		Percent of Wait Time Contracted Volumes Achieved				R	Y	
		Total Inpatient Admissions	G	G	G	G	G	↑
		Total Inpatient Weighted Cases	G	G	G	G	N/A	↑
E1 People	Lost time injury claims are reduced by 10%	Lost Time Injury Claims	N/A	N/A	N/A	R	Y	
		Musculoskeletal Injuries (MSIs)	G	G	R	G	R	↓
		Percent Completion of Incident Investigations	R	R	R	R	R	↑
		Reduction in Needle Stick Injuries	N/A	N/A	N/A	R	Y	

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
E1 People	Lost time injury claims are reduced by 10%		Reduction in Lost Time Injury Claims due to Musculoskeletal Injuries	N/A	N/A	N/A	R	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	G	G	Y	Y	↓
			Total Full Time Equivalents (FTE's)	G	Y	Y	G	G	↑
E4 Technology	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	R	R	
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 ($000's)			Y	Y	Y	↑
			Total Margin	G	G	G	G	G	↑
			Working Capital ($000's)	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

Kingston General Hospital

Quality Improvement Plan (QIP)

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
SD1 Transform the patient experience through a relentless focus on quality, safety and service	15 Patient experience advisors are integrated into		Number of Patient Experience Advisors on Key Planning/Decision Making Forums	R	Y	Y	G	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 Responding "Satisfied" to the KGH Environmental Patient Discharge Survey (QIP)	R	Y	Y	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	R	G	Y	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)	R	G	G	N/A	N/A	
			Percent Mortality Reviews Completed with Quarterly Review of Record Level HSMR Data	N/A	R	R	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	Y	R	R	Y	↑
			C-difficile (QIP)	G	R	R	G	R	↑
			Environmental Audits	Y	G	G	Y	G	↑
			Percent of Sepsis Cases Reviewed by Department Head	N/A	N/A	N/A	N/A	N/A	
			Ventilator Associated Pneumonia (QIP)	G	G	G	G	G	↑
	We achieve 100% hand hygiene compliance across		Hand Hygiene Compliance (QIP)	N/A	N/A	N/A	Y	Y	
	100% of our clinical services discharge patients at their expected LOS		Average # ALC Patients per Day	G	G	G	R	R	↑
			Percent ALC Days	R	R	R	Y	Y	↑

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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 CMG's	G	R	N/A	N/A	N/A	
	The ED wait time for admitted patients is less than 8 hrs for		90th Percentile ED Wait Time (All Admitted Patients)	Y	R	R	G	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	N/A	N/A	N/A	G	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		Percent of Discharge Communication sent to Continuing Care Provider within 72 hours of Patient Discharge	N/A	N/A	N/A	R	R	
E5 Finances	Our operating deficit is eliminated and our capital spend		Total Margin	G	G	G	G	G	↑

Indicates worsening performance to target over the past 5 quarters ↓

Indicates improving performance to target over the past 5 quarters ↑

Kingston General Hospital

Strategy Scorecard (SSC)
Per Annual Corporate Plan

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
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	Y	Y	G	G	↑
	Overall patient satisfaction is at or better than the prov. teaching average		Overall Acute Care Patient Satisfaction (%)	G	G	G	N/A	N/A	↓
	70% of our people who are surveyed rate us as 'excellent'		Percent of Staff surveyed who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	N/A	N/A	R	R	N/A	↓
	The number of new cases who acquire infections in our hosp. reduced by 10%		Number of New Cases of Hospital Acquired Infection	G	R	R	G	Y	↑
	We achieve 100% hand hygiene compliance across all units and staff		Hand Hygiene Compliance (SSC)	N/A	N/A	N/A	Y	Y	
	100% of our clinical services discharge patients at their expected LOS		Percent of Clinical Services Meeting ELOS Target	R	R	R	R	N/A	↑
	90% of patients receive their elective surgery within or faster than target		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	N/A	N/A	R	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	N/A	N/A	N/A	G	G	↑
	The KGH Interprofessional education council		IPE Work Plan Launched	N/A	N/A	G	G	G	↑
SD3 Cultivate patient oriented research	Externally funded research at KGH has increased by 10%		Percent Increase of Externally Funded Research Dollars at KGH	N/A	N/A	N/A	N/A	G	
SD4 Increase our focus on complex-acute and specialty care	KGH clinical staff adopt evidence-based guidelines		Number of Clinical Areas that have Implemented Open Source (OS)	N/A	N/A	N/A	G	R	
	KGH services align with our role as the region's complex-acute		KGH Cancer Care Plan	N/A	N/A	N/A	G	G	
	100% of Target service volumes are met		Percent of Wait Time Contracted Volumes Achieved	N/A	N/A	N/A	R	Y	

				10-Q2	10-Q3	10-Q4	11-Q1	11-Q2	
E1 People	Lost time injury claims are reduced by 10%		Lost Time Injury Claims	N/A	N/A	N/A	R	Y	
	Average sick days per KGH employee are reduced to 10.5		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
	100% of our staff complete mandatory online training		Percent of Staff that Complete Mandatory Online Training Programs	N/A	N/A	N/A	R	Y	
E2 Processes	100% of KGH managers complete mandatory process		Percent of Management Staff Completing Mandatory Process Improvement Training	N/A	N/A	N/A	Y	R	
E3 Facilities	Our new solar farm is established and 50% of carpets are removed		Percent of Square Footage of Carpet Removal Complete	N/A	N/A	N/A	G	G	
	96% of our Phase 1 redevelopment is complete on time		Phase 1 Redevelopment is Completed on Time and On Budget	N/A	N/A	N/A	G	G	
E4 Technology	50% of our automated medication dispensing system is in place		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	N/A	N/A	N/A	G	R	
	Our lab and diagnostic imaging order management		Implementation of an Order Management System for Labs on All Inpatient Areas (% completion).	N/A	N/A	N/A	G	R	
	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	N/A	N/A	R	R	
E5 Finances	Our operating deficit is eliminated and our capital spend		Total Dollars for Capital Equipment ($000's)	N/A	N/A	Y	Y	G	↑
E6 Communication	Patient, staff, and stakeholder engagement takes place		Implementation of Improved Website and Social Media Tools	N/A	N/A	N/A	G	G	

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