fiscal
2012-2013 **Q2**

2nd quarter ended September 30, 2012

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

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KGH Master Performance Report
Q2 Fiscal 2012 - 2013

KGH 2015

Outstanding Care, Always

Strategic Direction 1

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

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- Diagnostic Imaging – MRI – 90th Percentile Wait Time (days)
- Percent of non-admitted low acuity patients (CTAS 4&5) treated within a wait time Target of <4hrs
- Percent of clinical services meeting or exceeding 90th percentile wait time targets (excluding cancer surgery)
- All Cancer Surgery Wait Time – 90th Percentile days
- Orthopedic Hip and Knee Replacement Surgery Wait Time 90th percentile days
- Patients admitted from the Emergency Department (ED) with complex conditions - 90th percentile wait time (hrs)
- All Paediatric Surgery Wait Time 90th Percentile Days
- Cardiac Bypass Surgery – 90th Percentile Wait Time (days)
- Coronary Angiography – 90th Percentile Wait Time (days)
- Coronary Angioplasty – 90th Percentile Wait Time (days)
- Diagnostic Imaging – CT – 90th Percentile Wait Time
- General Surgical Procedures (excluding confirmed and suspected cancer surgeries) – Wait Time 90th Percentile days
- Percent of wait time contracted volumes achieved
- Radiation Wait Time (Referral-Consult) Percent seen within 14 days

Milestone 10: Cancer Care Ontario access to care indicators are met **Page 59**

- Number of Cancer Care Ontario access to care contract indicators met (Radiation/Chemotherapy)
- Percent of Cancer Care Ontario access to surgical care contract indicators met
- All Cancer Surgery Wait Time – 90th percentile wait time (days)

Strategic Direction 2

Bring to life new models of interprofessional care and education

N/A

Milestone 11: Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project) **Page 64**

- Automation of interprofessional assessment & adverse reaction documents is Complete as part of the e-doc project

Milestone 12: Workplan to fulfill interprofessional education competencies completed **Page 67**

- Number of interprofessional organizational educational competencies are met

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Strategic Direction 3

Cultivate patient oriented research

Strategic Direction 4

Increase our focus on complex-acute and specialty care

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Technology

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Enabler 6

Communication

Strategy milestone # 1

100% Accreditation Canada requirements are met with an unconditional three-year award

Strategic Direction	KGH 2015 outcome	Status
KGH 2015	Outstanding Care Always	Green

Indicator
100% Accreditation Canada Requirements Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The September 2012 Accreditation Canada (AC) survey was very successful resulting in an award of Accredited with Exemplary Status. We achieved 98.9% of the standards and met all Required Organizational Practice. This improvement in performance and increase by two levels in accreditation is testament to the structures and process in place at KGH to support quality and safety in patient care and services.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The success in the survey process is multifactorial. The presence of a strategy with clear principles that guide decision making, actions and allocation of resources has been critical to the focus on quality and safety. The preparation process also supported all staff being aware of standards and ROP's, and enabled assessments, education and correction actions over the past year. Implementation of regular rounds to profile achievements as well as opportunities with safety and quality created an ever present profile on Accreditation and performance.

3. **Are we on track to meet the milestone by year end?** The achievement of an unconditional award has been met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** To sustain and further improvements, work will continue to embed a means of weekly rounds as part of a safety/quality plan; programs and services have received their specific reports from Accreditation Canada and will continue to ensure compliance with any unmet standards; KGH will pursue submission of leading practices to AC as recommended in the report.

Kingston General Hospital

MS #01

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
KGH 2015	100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award	100% Accreditation Canada Requirements Met	N/A	N/A	N/A	G	G

Indicates improving performance to target over the past 5 quarters

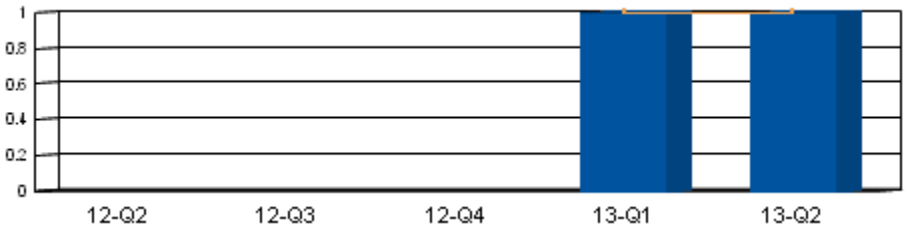
Indicates worsening performance to target over the past 5 quarters

MS #01

KGH 2015

100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award

Indicator: 100% Accreditation Canada Requirements Met



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	1	**1**
13-Q2	1	**1**

Interpretation - Patient And Business:

KGH underwent Accreditation Canada survey September 2012. Report received at end of September indicated and award of Accredited with Exemplary Standing. 98.9% of the standards and all Required Organization Practices were met. This is improvement from the 2009 survey when we received Accreditation with condition and met 94.3% of standards.

Actions & Monitoring Underway to Improve Performance:

The success of the survey has been messaged to staff and community with transparency of the detailed report on the intranet and website. All teams have received the details from the final Accreditation Report with expectation of sharing within programs and services and continuing work to sustain the achievements and address any unmet standards. The weekly accreditation rounds that were initiated as part of the preparation process will continue and transition into quality/safety rounds.

Definition: In September 2012 Kingston General Hospital will undergo an accreditation survey by Accreditation Canada. The Accreditation Canada survey process is one that enables health care organizations to assess their performance against national standards set by Accreditation Canada. Accreditation is essential to any hospital wishing to remain an academic centre. KGH voluntarily participates in this process, and was last surveyed in September 2009. At that time, KGH was assessed as meeting 94% of applicable national accreditation standards. To support the achievement of Outstanding Care Always, KGH is striving to achieve 100% performance against Accreditation Canada requirements to obtain a three year unconditional accreditation standing.

Target: Target 12/13: Q1 - Mock Surveys. Q2- Quality Road Map Submissions Completed. Q3-Accreditation Survey Occurs. Q4-Responding to results

Strategy milestone # 2

Quality Improvement Plan targets are met

Strategic Direction	KGH 2015 outcome	Status
KGH 2015	Outstanding Care Always	Yellow

Indicator
Number of Quality Improvement Plan Goals for Change Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Of the 20 indicators in the QIP, 5 are green, 5 yellow, 7 red and 3 remain N/A. Last quarter there was 9 green. Loss of green was seen in the implementation of the surgical safety check list, percent of patients satisfied on the environmental discharge survey, acute average LOS vs ELOS and the KGH 30 day readmission rate as per the SE LHIN CMG profile. Other losses (yellow to red) were seen in the three phases of the surgical safety checklist, C difficle rate and 90th percentile ED Wait times.

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

   Of the red indicators, stretch goal targets by the LHIN for readmission rates and ED wait times are likely beyond achievable.

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

   No. Conversion of the 5 yellow indicators to green is achievable. The conversion of 5 of 7 red to meet the target of 14 QIP indicators at green will be a challenge.

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

   Individual portfolio initiatives are focused on improving the discharge summary by 72 hour indicator and should show improvements. Implementation of the antibiotic stewardship program in August is showing effect with an improvement in a decreased antibiotic dispensing and C difficle rates.

Kingston General Hospital

MS #02

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
KGH 2015	Quality Improvement Plan Targets are Met	Number of Quality Improvement Plan Goals for Change Met	N/A	N/A	N/A	Y	Y

Indicates improving performance to target over the past 5 quarters

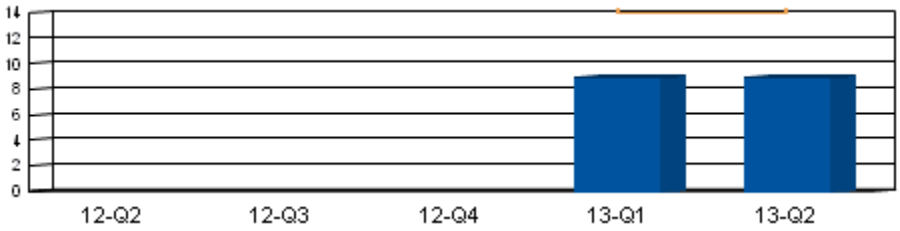
Indicates worsening performance to target over the past 5 quarters

MS #02

KGH 2015

Quality Improvement Plan Targets are Met

Indicator: Number of Quality Improvement Plan Goals for Change Met



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	9	**14**
13-Q2	9	**14**

Interpretation - Patient And Business:

The 2012/13 QIP has a total 14 indicators with an identified "Methods and Processes Measure" and a "Goal for Change". As of Q2, 9 were on target and 5 were red. The 5 reds are as follows, Patient food satisfaction, three phases of surgical saftey checklist, sepsis review, ED consult time, and 72 hr discharge summary.

Actions & Monitoring Underway to Improve Performance:

The Patient Safety and Quality Committee and the Joint Quality and Utilization Committee of MAC will need to provide effort and focus on the red indicators (Acute vs. Expected LOS; Mortality reviews by Departments; Patient satisfaction surveys on food and cleanliness; Discharge summaries sent within 72 hrs.)

Definition: The KGH is now in year 2 of the Province's Quality Improvement Plan (QIP). The QIP for fiscal 12/13 is made up of 22 indicators that were approved and submitted to the MOH in April 2012. In an effort to integrate the overall quarterly performance of the QIP into the Strategic Performance Report a roll-up indicator on overall QIP performance has been developed. This indicator reports on the percentage of the QIP indicators that are currently meeting target.

Target: Target 12/13: 14 of 14

Strategy milestone # 3

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

Strategic Direction	KGH 2015 outcome	Status
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**	**Green**

Indicator
Overall Acute Inpatient Satisfaction (%)

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The Q1 data from NRC Picker indicates that KGH is equivalent to the Ontario teaching hospital average., and therefore meeting the target.

2. **What are the contributing factors to the current performance of the indicators for this milestone? S**taff/advisors continue to attend both internal and external educational events about Patient and Family Centred Care (PFCC), which increases the capacity within KGH for promoting the understanding and practice of patient engagement in planning and decision making. There are now more than 50 advisors involved in program and corporate work. The profile that KGH has gained with the NRC Picker Award , and with external presentations is heightening the awareness, interest, engagement, and pride that staff have with this work. While satisfaction with food remains below target, results are improving, and Food Services continues to be responsive to feedback.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Preparatory work for the patient led feedback forums has been completed , with trials in a number of areas. Processes are in place to prepare the patients/families in telling their stories and in supporting the managers in both facilitating the feedback and utilizing it as part of continuous improvement. The forums are slated to be launched Q3. As well, Patient satisfaction results continue to be shared with programs, the PFAC and the Patient Safety and Quality Committee for consideration and suggestions of areas to address. In September, a team reviewed activities and opportunities with PFCC, collaborative model of care and Interprofessional Education , with the outcome of identifying ways through communication, education and the physical environment to that we can advance transformation of the patient experience. An action plan will be formulated to guide each of these now and in the next year.

Kingston General Hospital

MS #03

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
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	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
		Overall, How Would You Rate the Care You Received at the Hospital?	G	G	Y	G	N/A	↑
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	N/A	N/A	G	G	
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey *	R	R	R	R	N/A	↑
		Percent of Patients Who Answer "Definitely Yes" to the NRC Picker Question "Would You Recommend this Hospital to Your Friends and Family?"	G	G	Y	G	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

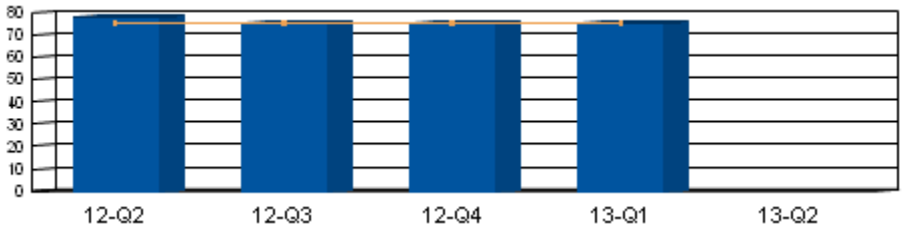
Kingston General Hospital

MS #03

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
12-Q2	78	**75**
12-Q3	75	**75**
12-Q4	75	**75**
13-Q1	75	**75**
13-Q2		

Interpretation - Patient And Business:

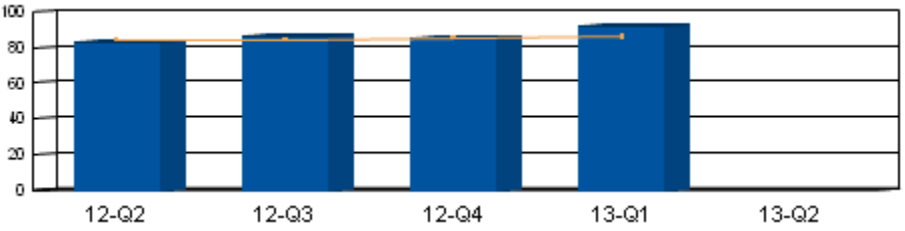
The current overall acute care satisfaction as with the previous quarter is on par with our target.

KGH currently scoring on par with the ON Teaching Hosp Av on 5 of the 8 dimensions and is within 2% of the ON Teaching Hosp Av in the remaining 3 dimensions. KGH scored over 80% satisfaction in the dimensions of physical comfort, respect for patient preferences and access to care.

Definition: NRC Picker categorizes the majority of its acute care inpatient satisfaction survey questions under eight distinct dimensions of care: access to care, emotional support, information and education, involvement of family, respect for patient preferences, continuity and transition, physical comfort, and coordination of care. The resulting percent positive score represents an aggregate of these eight dimensions of care combined.

Target: Baseline 08/09: 93.3, Target 09/10: 93.8 or Greater, Target 10/11: Provincial Teaching Avg. or Better, Target 11/12: PTAOB, Target 12/13: PTAOB

Indicator: Overall Emergency Care Patient Satisfaction (%)



	Actual	Target
12-Q2	83	**84**
12-Q3	86	**84**
12-Q4	85	**85**
13-Q1	92	**86**
13-Q2		

Interpretation - Patient And Business:

This indicator captures the overall quality of ED care from the patient experience perspective.

KGH score of 92% is well above our target of the ON Teaching Hosp Av of 86%.

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.

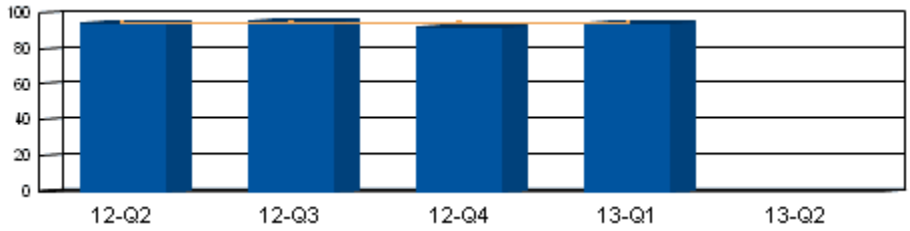
Target: Baseline 08/09: 83.1, Target 09/10: 80.0 or Greater, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: PTAOB Target 12/13: PTAOB

MS #03

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, How Would You Rate the Care You Received at the Hospital?



	Actual	Target
12-Q2	94	**94**
12-Q3	95	**94**
12-Q4	92	**94**
13-Q1	94	**94**
13-Q2		

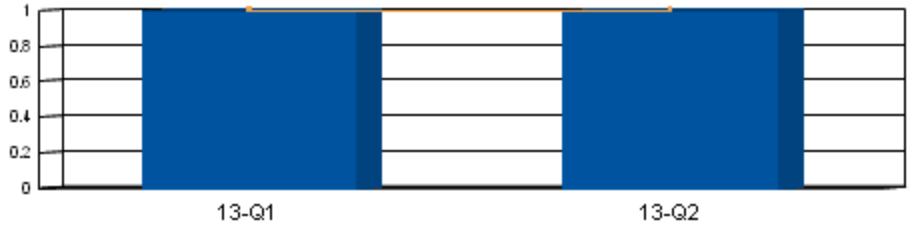
Interpretation - Patient And Business:

KGH is meeting the ON Teaching Hosp Avg. target of 94%

Definition: The patient's perception of overall care received and is based on a single question (#44) on the NRC Picker patient satisfaction inpatient corporate survey. Possible responses to this question include poor, fair, good, very good and excellent. The percent positive score represents the combined responses of good, very good and excellent.

Target: Target: PTAOB

Indicator: Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *



	Actual	Target
13-Q1	1	**1**
13-Q2	1	**1**

Interpretation - Patient And Business:

Preparatory work for patient led forums, including preparing patients and families to provide feedback and support for managers in both facilitating the forum and utilizing feedback as part of continuous improvement, has been completed. Few areas have trialed the forums to support development of materials. Launch in programs slated for Q3 and 4.

Actions & Monitoring Underway to Improve Performance:

Forums to be initiated in Q3. Learnings from that forum will re-shape the process in preparation of all Programs completing a forum before March 31st.

Definition: "Patient Led Forums" will be a vehicle by which patients, families, staff and physicians will be supported in coming together to understand and respond to recent patient experiences at the Program level. The impetus behind this endeavor is to understand better the hospital experience from the patient and family perspective and to be responsive to that experience by rectifying areas of concern and/or supporting areas of strength.

Target: Target 12/13: 100% -- Q1 - Establishment of a Patient and Family Feedback Task Team, Q2 - Creation of a tool kit, Q3 - One Forum launched, Q4 - One Forum in all Programs

---

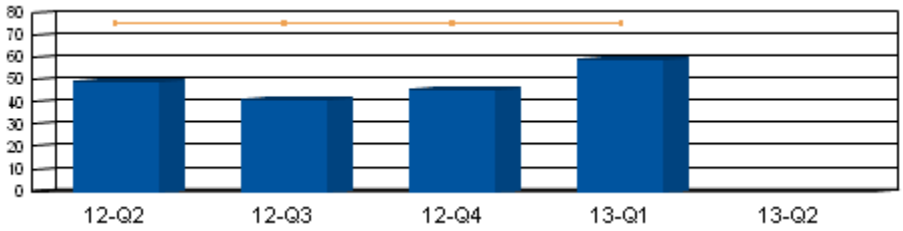
Kingston General Hospital

MS #03

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 Respond "Satisfied" to the Food Patient Discharge Survey *



	Actual	Target
12-Q2	49	**75**
12-Q3	41	**75**
12-Q4	46	**75**
13-Q1	59	**75**
13-Q2		

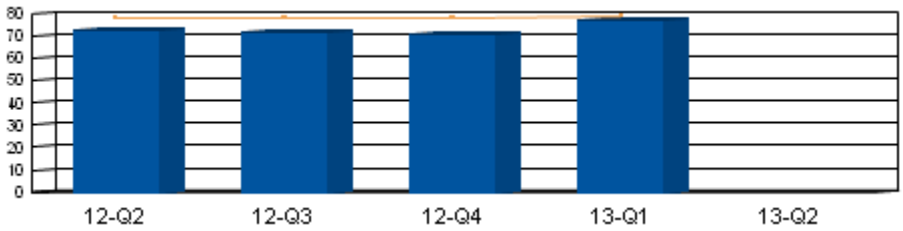
Interpretation - Patient And Business:

KGH results for this quarter showed a 13% increase in satisfaction nearing our target of 75%. Our result of 59% is on par with the ON Teaching Hosp Av.

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% -- Target 12/13: 75%

Indicator: Percent of Patients Who Answer "Definitely Yes" to the NRC Picker Question "Would You Recommend this Hospital to Your Friends and Family?"



	Actual	Target
12-Q2	73	**78**
12-Q3	72	**78**
12-Q4	71	**78**
13-Q1	77	**79**
13-Q2		

Interpretation - Patient And Business:

The question supports the overall acute care patient satisfaction and is a good indicator of the overall patient experience. KGH result this quarter is 6% higher than the previous quarter and well within striking distance of meeting the ON Teaching Hosp Av.

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: Target 11/12: PTAOB Target 12/13: PTAOB

Strategy milestone # 4

Patient safety culture ratings improve by 20%

Strategic Direction	KGH 2015 outcome	Status
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Red**

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

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

   Of the 8 indicators in this milestone 4 are green, 1 yellow and 3 red. Two of the red indicators are linked to the utilization of the surgical check list in the operating room.

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

   A change in the indicator to include 3 phases of reporting and the new electronic system in the operating room (PICS) have contributed to the decreased performance.

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

   Yes. Initiatives underway to support improved survey results – accreditation feedback, Patient Safety walkabouts, Patient Safety Week.

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

   The new PICS system will allow better data collection to improve the surgical safety checklist. A refreshed accountability profile in the operating room along with the PICS system should see improvement in the red indicator.

Kingston General Hospital

MS #04

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	Patient safety culture ratings improve by 20%	Percent of Staff Surveyed Who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	N/A	N/A	R	N/A	N/A	↓
		Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	N/A	N/A	G	G	
		Implementation of Surgical Safety Check List	G	G	G	G	R	↓
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	G	N/A	N/A	N/A	N/A	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	Y	Y	Y	R	↓
		Hospital Standardized Mortality Ratio (HSMR)	G	R	G	N/A	N/A	↑
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	G	G	Y	N/A	↑
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	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 ↓

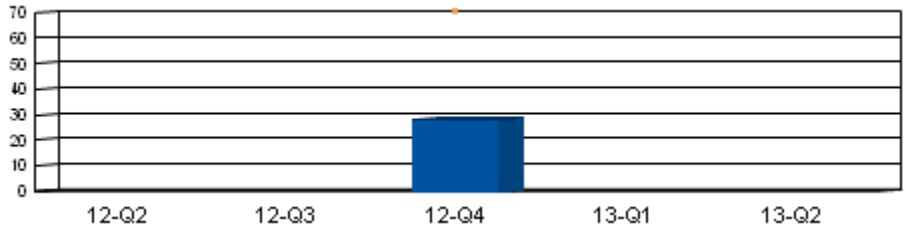
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

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



	Actual	Target
12-Q2		
12-Q3		
12-Q4	28	70
13-Q1		
13-Q2		

Interpretation - Patient And Business:

Next patient safety culture survey will be done in the spring of 2013.

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.

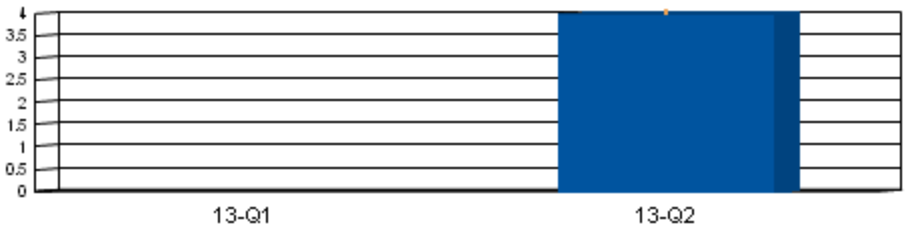
The Patient Safety Culture Tool includes 40 items (plus demographic items). Two items assign an overall patient safety grade of the unit and the organization. The remaining 38 items measure the following dimensions:
- Senior leadership support for safety
- Supervisory leadership support for safety
- 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%, Target 12/13: 48%

Indicator: Number of Clinical Programs that Implement at Least One New Safety Checklist



	Actual	Target
13-Q1		
13-Q2	4	4

Definition: A checklist is a list of action items arranged in a systematic manner that allows the user to record the completion of the individual items. The goals of checklists used in healthcare are primarily error reduction and adherence to best practices in clinical care. The aim of a checklist is to reinforce accepted safety practices and foster better communication and teamwork between clinical disciplines. Its use has been demonstrably associated with significant reductions in complication and death rates in hospitals and with improvements in compliance to basic standards of care. This indicator tracks the number of new safety checklists that have been implemented throughout the hospital.

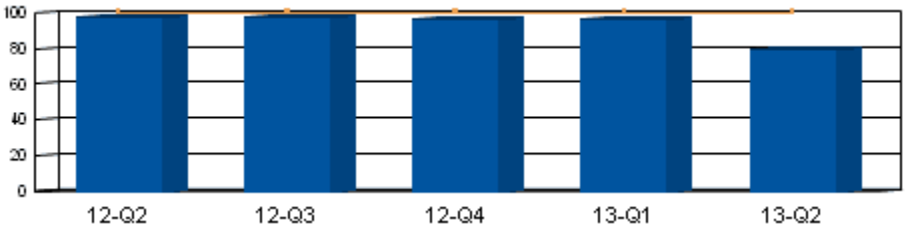
Target: Target 12/13: 4

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: Implementation of Surgical Safety Check List



	Actual	Target
12-Q2	97	**100**
12-Q3	97	**100**
12-Q4	96	**100**
13-Q1	96	**100**
13-Q2	80	**100**

Interpretation - Patient And Business:

Influencing the decline of 16 % in this quarter for this indicator is the implementation of a new database system (ORSOS to PICIS) in the Operating room that changed the reporting of the surgical safety checklist. Previously the ORSOS system documentation requirement was a simple Yes/No overall response to whether or not the 3 phases were being completed (briefing, time out, and debriefing). With the first phase of the PICIS implementation in place the requirement is to manually record accurate times for the completion of each phase therefore if only 2 of the 3 times are recorded on the checklist the data is considered invalid.

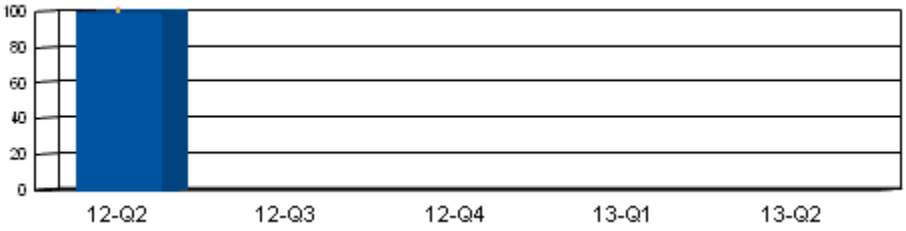
Actions & Monitoring Underway to Improve Performance:

With the implementation of the 2nd phase of PICIS electronic documentation system improvements to the documentation of compliance will occur due to a default feature that will not permit progressing with completion of the record until the times for all three phases of the surgical safety checklist are inputted.

Definition: This Surgical Safety Checklist (SSC) compliance indicator is a process measure that is part of the hospital's QIP. It measures overall compliance of the initial phase (the "Briefing") of the surgical safety checklist for each surgical patient. All surgeries carried out in a fully equipped operating room are eligible to report the use the SSC. The SSC is considered performed when the designated checklist coordinator confirms that surgical team members have implemented and/or addressed all of the necessary tasks and items in each of the three phases-'Briefing', 'Time Out' and 'Debriefing'-of the checklist, based upon the Canadian Patient Safety Institute (CPSI)'s Surgical Safety Checklist.

Target: Target 12/13: 100%

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



	Actual	Target
12-Q2	100	**100**
12-Q3		
12-Q4		
13-Q1		
13-Q2		

Interpretation - Patient And Business:

Data delayed due to CIHI HSMR calculation being unavailable.

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

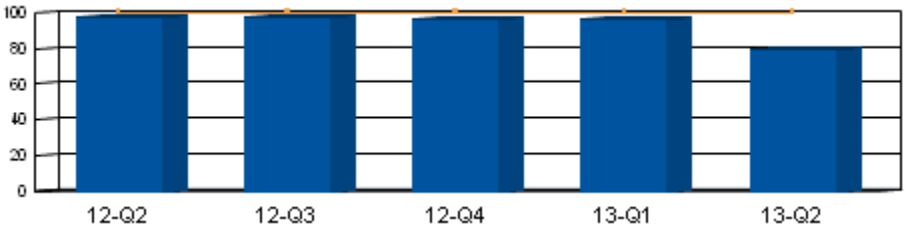
Target: QIP Target 11/12: 75% Target 2012/13: 100%

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *



	Actual	Target
12-Q2	97	**100**
12-Q3	97	**100**
12-Q4	96	**100**
13-Q1	96	**100**
13-Q2	80	**100**

Interpretation - Patient And Business:

With the new PICIS electronic documentation system, the reporting of the 3 phases of the surgical checklist will be more accurate in the accounting of compliance and will assist in identifying services that need to focus on improvement. This system change will also influence peer benchmarking data as organizations that continue to use the older version of manual reporting with a Yes/ No response will continue to register as high achieving centres compared to KGH until we adapt to the newer reporting system.

For June to October, the overall 3 phase reporting identifies the first phase (brief) as completed 93 % of the time, second phase (timeout) as completed 92 % of the time and the last phase (debrief) is documented as completed as only 84% of the time. Included in this data capture is emergency and elective time that will contribute to the difference from Q1 as previously only elective time was reported.

Actions & Monitoring Underway to Improve Performance:

Program leadership will be organizing a task group tol focus on re-educating interprofessional teams on the importance of capturing all elective and urgent case as directed by new guidelines from the ministry as well as ongoing performance monitoring wil be conducted by the SPA Leadership Committee.

Definition: The Surgical Safety Checklist (SSC) compliance indicator is a process measure, that is part of the hospital's QIP. It refers to the percentage of surgeries in which a three-phase surgical safety checklist was performed correctly and appropriately for each surgical patient. All surgeries carried out in a fully equipped operating room are eligible to report the use the SSC. The SSC is considered performed when the designated checklist coordinator confirms that surgical team members have implemented and/or addressed all of the necessary tasks and items in each of the three phases-'Briefing', 'Time Out' and 'Debriefing'-of the checklist, based upon the Canadian Patient Safety Institute (CPSI)'s Surgical Safety Checklist.

Target: Target 2012/13: 100%

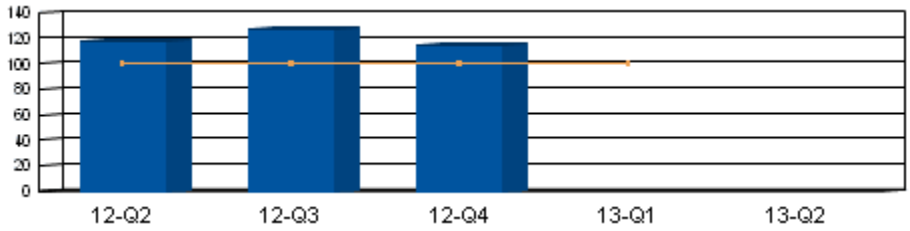
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
12-Q2	117	**100**
12-Q3	127	**100**
12-Q4	114	**100**
13-Q1		**100**
13-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.

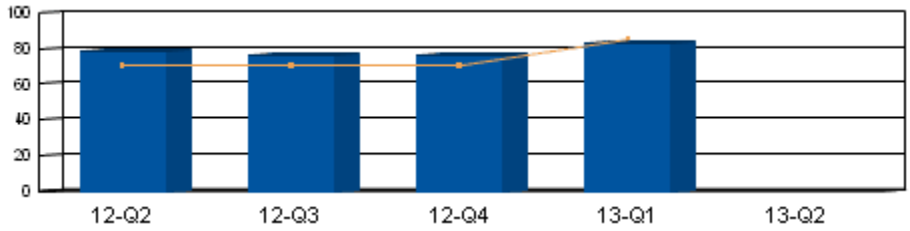
Actions & Monitoring Underway to Improve Performance:

The most recent data available data is Q3 fiscal 10/11. The HSMR has risen slightly and for Q3 fiscal 10/11 was deemed statistically significant. However, it is important to note that our HSMR has been dropping steadily for the past 5 years. The Canadian Institute for Health Information (CIHI) provides the HSMR calculations to all hospitals in Ontario. Quarterly morality reviews are on-going by the clinical departments. Any concerns or trends are reported to the MAC's Joint Quality and Utilization Committee. Of note is a continued drop on the 5 year ANNUAL mortality rate.

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. Target 12/13: 100

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



	Actual	Target
12-Q2	78	**70**
12-Q3	76	**70**
12-Q4	76	**70**
13-Q1	83	**85**
13-Q2		

Interpretation - Patient And Business:

The 83% is a significant improvement from our last quarter and represents the feedback which is received through the NRC + Picker Patient Satisfaction Survey which is conducted on discharge. Improvements are continuing with patient satisfaction.

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 and daily room cleaning.

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

Target: Target 2012/13: 85%

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *

	Actual	Target
13-Q1	100	**100**
13-Q2	100	**100**

Interpretation - Patient And Business:

Three (3) Critical Incident Reviews were held under the Quality of Care Information Act (QCIPA) from 2012 Jul-Sep. There were a total of 15 resulting recommendations. Eight (8) of these are complete and the outstanding six (6) are in progress. One (1) recommendation has been considered and will be acted upon/informed by other recommendations from the same review once complete.

Definition: The purpose of the Critical Incident review process is to assess and evaluate provision of health care resulting from a patient safety related incident with a view to improving or maintaining the quality of healthcare. The review team makes recommendations to prevent recurrence and assigns responsibility for implementation consideration of each recommendation. In addition, that there are fully implemented processes and reporting through CEO, Medical Advisory Committee and Patient Safety and Quality Committee to the Quality of patient care Committee of the Board.

Target: Target 2012/13: 100%

Strategy milestone # 5

Medication reconciliation is completed for every internal medicine program inpatient at admission

Strategic Direction	KGH 2015 outcome	Status
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Yellow**

Indicator
Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   A focus on this milestone within the Internal Medicine program has allowed a 93% of inpatients receiving a medication reconciliation.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Devoted pharmacy and pharmacy technicians to the medicine program have enabled the performance of 94%. Access to Order Sets (paper forms) for medication reconciliation has been identified as a concern and links to similar issues recognized in Milestone # 16.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Continued devoted support by Pharmacy to the program will ensure continued progress to the target of 100%.

Kingston General Hospital

MS #05

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	Medication reconciliation is completed for every internal medicine program inpatient at admission	Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission	G	G	G	G	Y	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

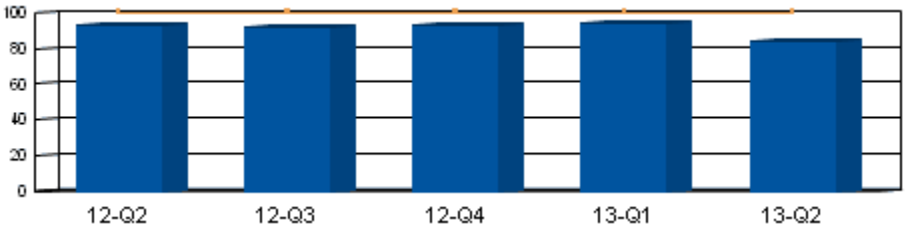
Kingston General Hospital

MS #05

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

Medication reconciliation is completed for every internal medicine program inpatient at admission

Indicator: Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission



	Actual	Target
12-Q2	93	**100**
12-Q3	92	**100**
12-Q4	93	**100**
13-Q1	94	**100**
13-Q2	84	**100**

Interpretation - Patient And Business:

A 10% decrease in compliance is seen for Fiscal 12/13 Q2 compared to previous four quarters. Physician support for medication reconciliation is critical to achieving the target of 100%.

Actions & Monitoring Underway to Improve Performance:

Pharmacy and Internal Medicine will review and address barriers to compliance.

Definition: Medication reconciliation (med rec) on admission is a process in which healthcare professionals work with patients and families to document an accurate and complete list of the patient's medication information at the time of admission to the hospital It is well demonstrated in the patient safety literature that completing the medication reconciliation process will significantly reduce the chance of a medication discrepancy during the hospital stay.

Target: Target 2012/13: 100%

Strategy milestone # 6

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

Strategic Direction	KGH 2015 outcome	Status
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Red**

Indicator
Number of New Cases of Hospital Acquired Infection

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   An increase in the C difficile rates and Central line infections has changed this from a Green milestone in Q1 to red. Key improvement was seen in the antibiotic dispensing. 4 of the 12 indicators are green, 4 yellow and 3 red (1 N/A).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The C difficile rates are falling by monthly reporting but certainly above quarterly reported rates. Significant concerns with the rising Central line infections. The implementation of the antibiotic stewardship program may be reflected in the decreasing C difficile rates and improved MRSA rates.

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

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

   Increase focus of the Infection Prevention and Control Service on education and presence on wards will support hand hygiene and contact precaution measures.

Kingston General Hospital

MS #06

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	The number of new patients who acquire infections in our hospital is reduced by 10%	Number of New Cases of Hospital Acquired Infection	Y	Y	R	G	R	↓
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *	Y	R	Y	Y	Y	↑
		Percent of Sepsis Cases Reviewed by Department Head *	N/A	N/A	N/A	N/A	N/A	
		C-Difficile (Reported Quarterly)	R	R	R	Y	R	↑
		C-Difficile (Reported Monthly)	R	R	R	R	R	↑
		Hand Hygiene Compliance *	Y	G	G	Y	Y	↓
		Central Line Bloodstream Infections	R	G	G	G	Y	↓
		MRSA (Methicillin-resistant Staphylococcus Aureus)	Y	G	G	Y	Y	↓
		VRE (Vancomycin-resistant Enterococcus)	Y	G	G	R	R	↑
		Ventilator Associated Pneumonia	G	G	R	R	G	↑
		Surgical Site Infection (SSI) Prevention	Y	Y	Y	G	G	↑
		External Environmental Audits by Westech	N/A	N/A	N/A	Y	Y	

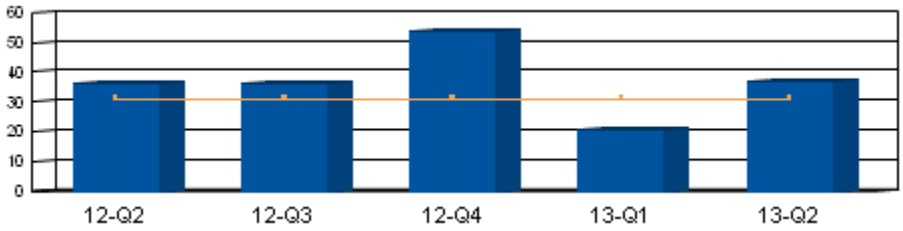
Indicates improving performance to target over the past 5 quarters ↑ Indicates worsening performance to target over the past 5 quarters ↓

MS #06

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

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

Indicator: Number of New Cases of Hospital Acquired Infection



	Actual	Target
12-Q2	36	**31**
12-Q3	36	**31**
12-Q4	54	**31**
13-Q1	21	**31**
13-Q2	37	**31**

Interpretation - Patient And Business:

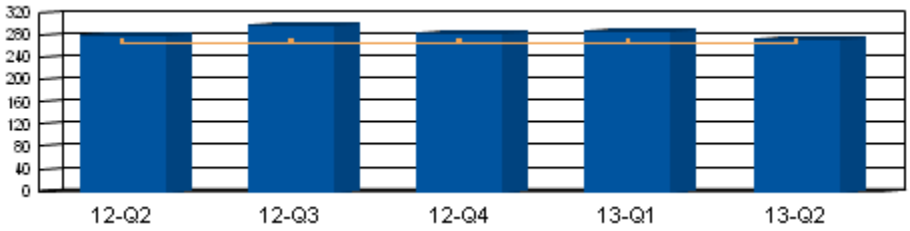
Patient Perspective: The increase in the number of HAI is mainly attributed to the slight increase in CDI from last quarter.

Business Perspective: Interventions put in place to address the increase in CDI are anticipated to stabilize and in line with the 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 Target 12/13: 31

Indicator: Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *



	Actual	Target
12-Q2	278	**267**
12-Q3	299	**267**
12-Q4	285	**267**
13-Q1	287	**267**
13-Q2	272	**267**

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. Fiscal 2012/13: 267

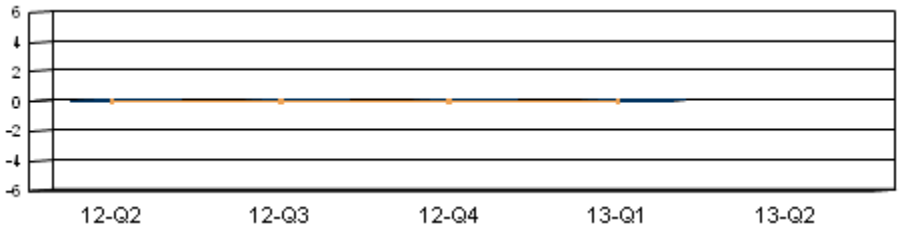
Kingston General Hospital

MS #06

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

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

Indicator: Percent of Sepsis Cases Reviewed by Department Head *



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1		
13-Q2		

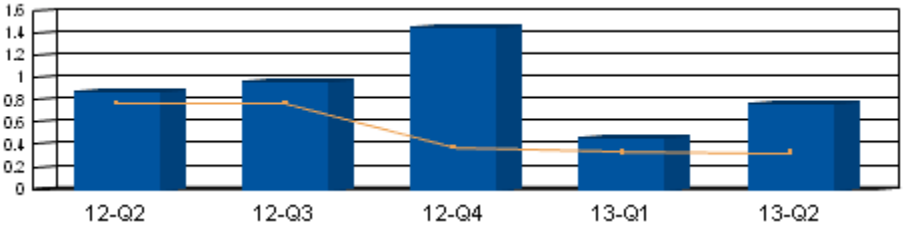
Interpretation - Patient And Business:

This indicator is going to be rolled into the mortality review process for Q3. The review of sepsis deaths will be a focus of the mortality review process.

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

Target: Target 11/12: 75%, Target 2012/13: 100%

Indicator: C-Difficile (Reported Quarterly)



	Actual	Target
12-Q2	0.9	**0.8**
12-Q3	1.0	**0.8**
12-Q4	1.5	**0.4**
13-Q1	0.5	**0.3**
13-Q2	0.8	**0.3**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.77 cases per 1000 patient days; an increase from the previous quarter. In July there were 11 cases of CDI with a few cases clustered on Connell 9. In August, the CDI Rate was slightly lower, 10 cases. In September, there were 7 cases, with 5 of these cases clustered on Connell 10. Although we did not meet our outbreak threshold, interventions were put in place on the unit and IPAC met with Public Health to discuss the situation.

Business Perspective: Measures implemented include: Emphasis on the implementation of and adherence to Contact Precautions including the appropriate use of PPE (gowns and gloves) and strict hand hygiene. In follow up to the meeting Public Health has had an opportunity to observe the environmental auditing process, and will review the Environmental Services training program in the near future. The launch of the Antimicrobial Stewardship Program (ASP) occurred in August and is proactively working to improve the appropriate antibiotic use in the hospital. An Order Set for CDI has been drafted and sent to the Antibiotic Stewardship Sub-Committee for approval. The order set's intent is to assist physicians in managing patients identified with CDI and improve outcomes.

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: Fiscal 2011/12 - QIP Goal = 0.30, QIP Target For Compensation = 0.77 Fiscal 2012/13: 0.3

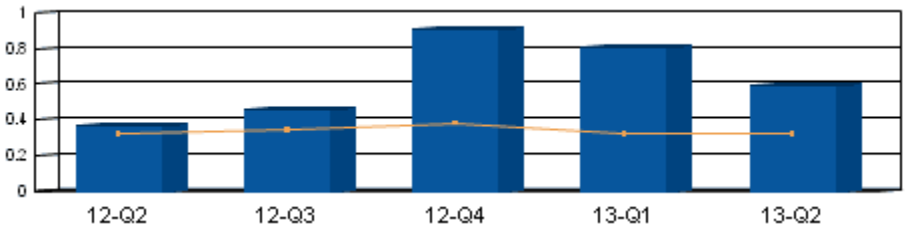
Kingston General Hospital

MS #06

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

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

Indicator: C-Difficile (Reported Monthly)



	Actual	Target
12-Q2	0.4	**0.3**
12-Q3	0.5	**0.3**
12-Q4	0.9	**0.4**
13-Q1	0.8	**0.3**
13-Q2	0.6	**0.3**

Interpretation - Patient And Business:

Please note the last 5 quarters are monthly values (May 2012 - Sept 2012)

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.

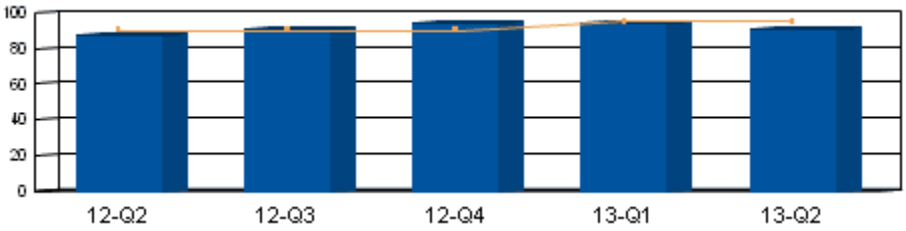
Target: Target 09/10: 0.26 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better Target 12/13: PAOB

MS #06

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

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

Indicator: Hand Hygiene Compliance *



	Actual	Target
12-Q2	87	**90**
12-Q3	91	**90**
12-Q4	94	**90**
13-Q1	94	**95**
13-Q2	91	**95**

Interpretation - Patient And Business:

Patient Perspective: In July, August and September patients continued to receive hand hygiene education from nursing and IPAC Service as we continued to address the changes in how KGH's manages patients with VRE. New Staff Orientation, Health Care Professional and Patient Care Assistants education sessions were updated and LMS module on Hand Hygiene was finished in collaboration with People Services. Continued attention to HH across the institution will be important to reducing the incidence of nosocomial infections overall.

Business Perspective: In Quarter 2, the 91.2% compliance rate was the result of 2726 observations, where 1671 HCP observed. There were 695 fewer observations completed which we attribute to the on-going process of upgrading from the former PDA model to the new iPod model. IPAC Service is continuing with the introduction of the new devices and education of hand hygiene auditors. The change over to the new device will assist us in improving the gathering of hand hygiene data due to improved functionality that will assist us in meeting our target.

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: Target 11/12: 90% Target 12/13: 95%

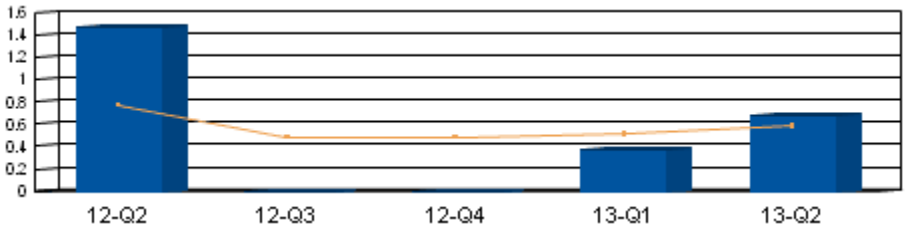
Kingston General Hospital

MS #06

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

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

Indicator: Central Line Bloodstream Infections



	Actual	Target
12-Q2	1.5	**0.8**
12-Q3	0.0	**0.5**
12-Q4	0.0	**0.5**
13-Q1	0.4	**0.5**
13-Q2	0.7	**0.6**

Interpretation - Patient And Business:

Related to the small denominator which means small numbers (3 pts in 3 months) impacts the rate. When compared with teaching hospitals, however, we are well below the CCIS target for that cluster which is the mean. The provincial mean for all hospitals include the many stepdowns in the province whose pts stay less than 2 days and hence fall off the definition for CLI giving them a rate of 0.

Actions & Monitoring Underway to Improve Performance:

continue to monitor closely and ensure compliance with CL bundle. Discuss with program's Safety Committee

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.

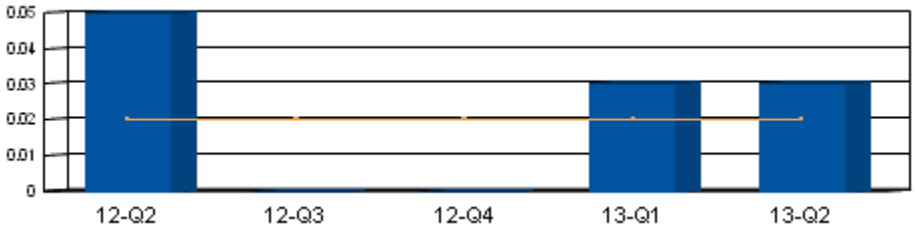
Target: Target 09/10: 1.2 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: PAOB Target 2012/13: PAOB

MS #06

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

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

Indicator: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
12-Q2	0.05	**0.02**
12-Q3	0.00	**0.02**
12-Q4	0.00	**0.02**
13-Q1	0.03	**0.02**
13-Q2	0.03	**0.02**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.03 which represents only one case.

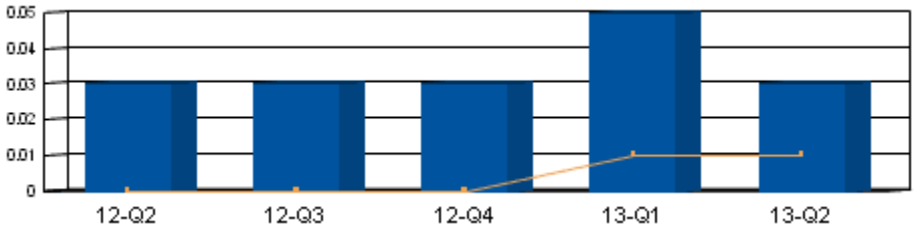
Business Perspective: Continued surveillance and isolation of MRSA cases, education and improvements in hand hygiene all contribute to efforts to achieve our target.

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

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

Target: Target 09/10: 0.02 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: PAOB, Target 2012/13: PAOB

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
12-Q2	0.03	**0.00**
12-Q3	0.03	**0.00**
12-Q4	0.03	**0.00**
13-Q1	0.05	**0.01**
13-Q2	0.03	**0.01**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0.03 which represents only one case.

Business Perspective: The hospital has reconsidered its in-house admission screening and implementation of Contact Precautions for known VRE patients. As of June 25th, 2012, KGH discontinued these practices. KGH IPAC continues to perform surveillance of VRE bacteremias and other infection and bacteremias will continue to be reported as required by the province.

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: PAOB, Target 2012/13: PAOB

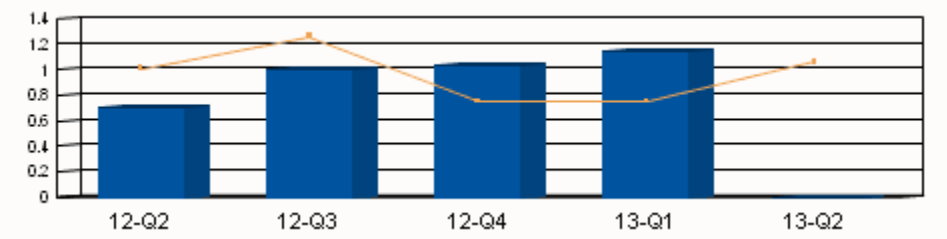
Kingston General Hospital

MS #06

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

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

Indicator: Ventilator Associated Pneumonia



	Actual	Target
12-Q2	0.7	**1.0**
12-Q3	1.0	**1.3**
12-Q4	1.0	**0.8**
13-Q1	1.1	**0.8**
13-Q2	0.0	**1.1**

Interpretation - Patient And Business:

Rate 0 this quarter, although small numbers can cause large fluctuations in rate. One or two cases in a quarter can cause the hospital to exceed its stretch target

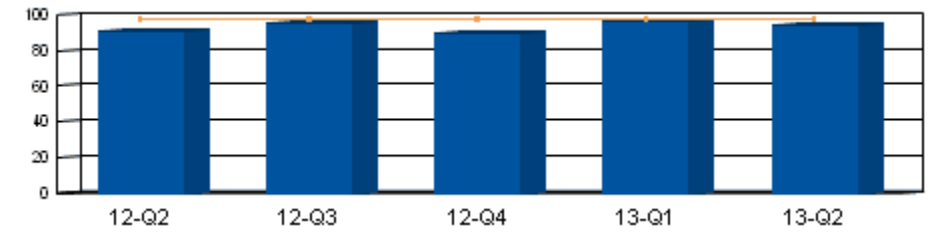
Actions & Monitoring Underway to Improve Performance:

continue with application of VAP bundle and monitor closely

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, Target 2012/13: PAOB

Indicator: Surgical Site Infection (SSI) Prevention



	Actual	Target
12-Q2	91	**97**
12-Q3	95	**97**
12-Q4	90	**97**
13-Q1	96	**97**
13-Q2	94	**97**

Interpretation - Patient And Business:

Patient Perspective: The rate of appropriate timing of prophylactic antibiotic administration for patients undergoing orthopedic procedures this quarter was 94%, just below the target of 97%.

Business Perspective: Combined efforts between IPAC and the SPA Program to ensure accurate documentation of the prophylactic antibiotic administration has enabled us to improve and come close to achieving our target. These efforts will continue.

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

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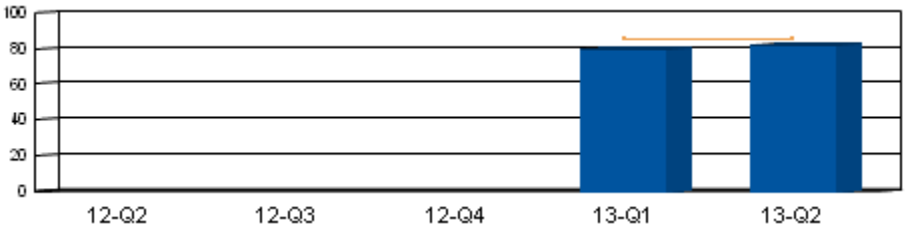
Kingston General Hospital

MS #06

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

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

Indicator: External Environmental Audits by Westech



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	80	**85**
13-Q2	82	**85**

Interpretation - Patient And Business:

The most recent Westech audit identified areas for improvement which has been communicated to both management and staff and actions have been identified. The 85% benchmark has been achieved in our patient care areas through our staff involvement.

Actions & Monitoring Underway to Improve Performance:

We have been involved with Westech since March 2011. The Westech cleaning standard is a very detailed cleaning audit that has required very extensive training of both staff and managers. Although improvement has been demonstrated work continues to achieve the 85% target.

Definition: Westech System Inc. is an external company that performs cleaning audits throughout the Hospital. The audit categorizes the many areas of the hospital into four (4) risk categories. Patient rooms are considered Risk 2 (High risk). The audit provides detailed areas for improvement to focus education and training required for staff and management.

Target: Target 2012/13: 85%

Strategy milestone # 7

KGH overall average length of stay is better than expected length of stay

Strategic Direction	KGH 2015 outcome	Status
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**	**Yellow**

Indicator
Overall – Acute Average Length of Stay vs. ELOS – Variance in Days

1. **What is our actual performance on each of the indicators for this milestone as listed above?** Based upon the Q1 data, this milestone has fallen below the target. The ALOS dropped to 6.3 days which is 0.2 day below the target. It is noteworthy however that the 2013 target is again a stretch target; that our current performance is below our ELOS and the best that it has been.. While still below target the percent of services meeting or exceeding the ELOS has increased from 72 to 78, and all are trending in a favourable direction. ALC however in Q2 has continued to increase.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The reduction in ALOS is due in part to the programs continued focus on tactics that improve aspects of care and patient flow including discharge prediction, discharge planning, consultation processes. Improved performance has been limited in part because of challenges with ALC numbers and repatriation of patients to regional facilities (likely downstream impact of LTCH bed closures).

3. **Are we on track to meet the milestone by year end?** Yes presuming continued effort on patient flow tactics, and regional support with repatriation and ALC.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** In summer 2012 with intake of new residents and staff, there was a refreshed education of ALC and Home First processes. KGH in engaging with community and regional partners in identifying barriers and opportunities to support patient transitions to other organizations. Providence Care now has representation on the Patient Flow Task Force (PFTF) and networking opportunities with LTCH's are being established. Information sharing about specific patients awaiting repatriation is now routinely conveyed to the VP's of local/regional hospitals to enable their decision support and planning. The Concurrent Review Process also provides insights into delays with internal consultation and discharge planning, and informs program tactics.

Kingston General Hospital

MS #07

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	KGH overall average length of stay is better than expected length of stay	Average # ALC Patients per Day	R	G	G	R	R	↓
		Percent ALC Days	Y	G	G	G	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	G	Y	Y	↑
		Percent of Clinical Services Meeting or Exceeding ELOS Target	R	R	R	R	R	↑
		Overall - Acute Average Length of Stay Days (Based on HSAA)	G	Y	Y	G	G	↑
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	Y	G	G	R	Y	↓
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	R	Y	N/A	N/A	N/A	↑

↑ Indicates improving performance to target over the past 5 quarters

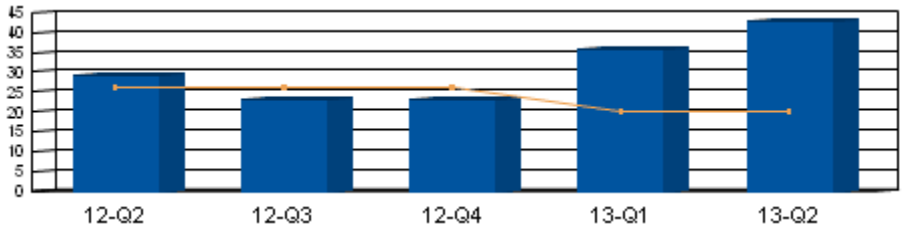
↓ Indicates worsening performance to target over the past 5 quarters

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Average # ALC Patients per Day



	Actual	Target
12-Q2	29	**26**
12-Q3	23	**26**
12-Q4	23	**26**
13-Q1	36	**20**
13-Q2	43	**20**

Interpretation - Patient And Business:

Result for Q2 is 43 (manual calculation pending results from ATC/WTIS).

Increase in average number of ALC patients is attributed to increases in designations to both long term care and rehab destinations. Internal factors include: increased patient activity in Medicine and Orthopedics throughout Q2; designation process challenges i.e. designations in advance of completed Home First assessments in some areas. External factors include: reduced availability of long term care beds; increased admission to these beds from community - crisis placements; indirect affect of closure of a long term care facility in Picton - affecting access to repatriation of acute patients to Quinte.

Actions & Monitoring Underway to Improve Performance:

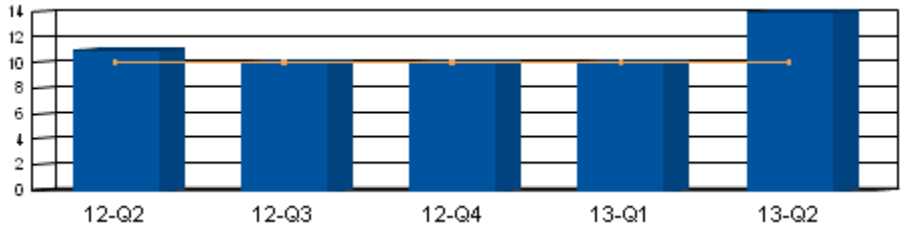
Ongoing education provided to Connell 9 and 10, Kidd 7, and planning for Kidd 4 on Home First with the aim of reducing conversion to ALC. Planning for education to Emerg regarding crisis placements to LTC from ER i.e. education to prevent this from occurring.

Case by case review and discussion/follow-up when agreed-to approved processes are not followed.

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. Target 12/13: 20

Indicator: Percent ALC Days



	Actual	Target
12-Q2	11	**10**
12-Q3	10	**10**
12-Q4	10	**10**
13-Q1	10	**10**
13-Q2	14	**10**

Interpretation - Patient And Business:

Q2 results are concerning given the impact on patients waiting for admission to LTC, and patients in ER waiting for admission to an acute care bed.

The Patient Flow Task Force will continue with oversight of the indicator. ALC rates, conversion rates and Home First trends are reviewed monthly with consideration of opportunities for improvement. Although the majority (on average>65%) of the ALC patients are awaiting discharge to long term care facilities, this past quarter has seen an increased number of ALC patients waiting for a rehab bed.

Actions & Monitoring Underway to Improve Performance:

Ongoing education and presentation of results with staff and physicians. Focus is on barriers to discharge.

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%, 12/13 Target: 10%

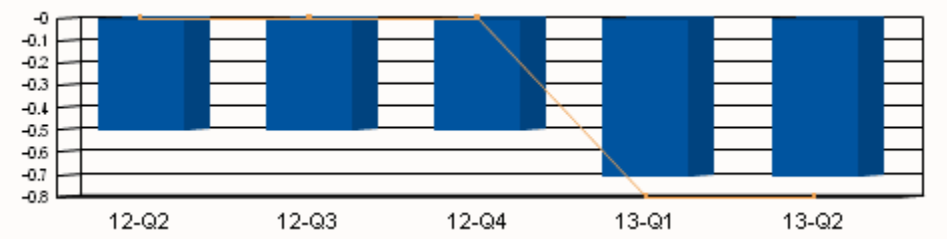
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Overall - Acute Average Length of Stay vs. ELOS Variance in Days - QIP *



	Actual	Target
12-Q2	-0.5	**0.0**
12-Q3	-0.5	**0.0**
12-Q4	-0.5	**0.0**
13-Q1	-0.7	**-0.8**
13-Q2	-0.7	**-0.8**

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q2. The -0.7 day variance for Q2 (fiscal 12/13) indicates that our overall actual length of stay remains below (or better) than our expected length of stay by 0.7 of a day, almost achieving our target of -0.8 days. However, it is important to note that this is calculated on an overall basis. There remains opportunity in 4 of 18 services to achieve expected length of stay. They are the services of Gastroenterology, Neurology, Obs and Gyn, Plastic Surgery.

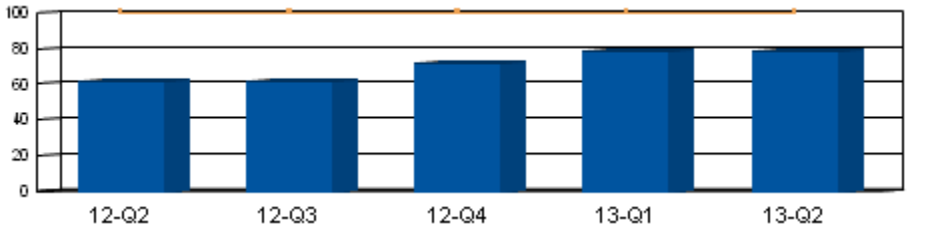
Actions & Monitoring Underway to Improve Performance:

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: Target 12/13: -0.8 Days

Indicator: Percent of Clinical Services Meeting or Exceeding ELOS Target



	Actual	Target
12-Q2	61	**100**
12-Q3	61	**100**
12-Q4	72	**100**
13-Q1	78	**100**
13-Q2	78	**100**

Interpretation - Patient And Business:

As of Q2 (fiscal 12/13), 78 percent of services (14 of 18) are achieving (or outperforming) their expected length of stay. The services that are not currently at their expected length of stay are Gastroenterology, Neurology, Obs/Gyn, Plastic Surgery

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: Target 12/13: 100%

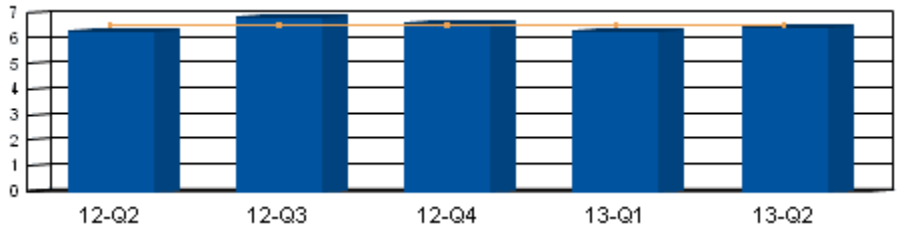
Kingston General Hospital

MS #07

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

KGH overall average length of stay is better than expected length of stay

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



	Actual	Target
12-Q2	6.3	**6.5**
12-Q3	6.8	**6.5**
12-Q4	6.6	**6.5**
13-Q1	6.3	**6.5**
13-Q2	6.4	**6.5**

Interpretation - Patient And Business:

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).

Actions & Monitoring Underway to Improve Performance:

The average length of stay for Q2 at 6.4 days putting remains below the target of 6.5 days. It is worth noting that at the same time are average length of stay comparedto expected length of stay is .7 days below our expected. There continues to be tremendous efforts placed on this achieving this target though the implementation of a variety of tacticss lead by a variety of disciplines.

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. Target 12/13: 6.5 Days

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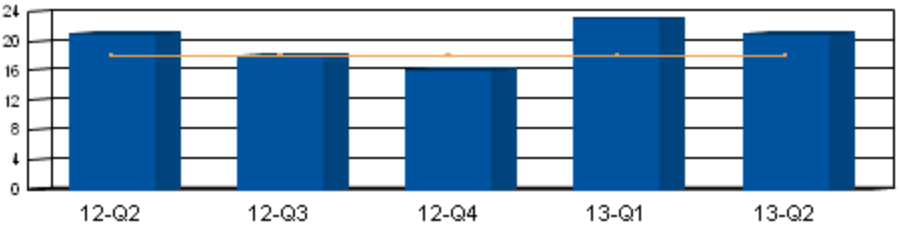
Indicator: Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *



	Actual	Target
12-Q2	21	**18**
12-Q3	18	**18**
12-Q4	16	**18**
13-Q1	23	**18**
13-Q2	21	**18**

Interpretation - Patient And Business:

The SE LHIN readmission metric is for a selection of CMGs primarily focused in cardiology, respirology, gastroenterolgy and neurology. Unplanned hospital admissions exact a toll on patients, families and the health care system. Avoidable readmissions is a system level issue that is liked to the integration of care along the continuum of care. Providing the right care in the right place at the right time can reduce hospital readmissions.

Actions & Monitoring Underway to Improve Performance:

The 30 day readmission rate is not target. Further analysis of these data at the Program/Department level using CMG performance will allow assessment of opportunities to further improve the readmission rates.

Definition: This indicator focuses on just on the readmission rate to KGH within 30 days of admission. It is defined as the number of patients readmitted to KGH for non-elective inpatient care divided by the total number of admissions. It will be calculated on a CMG basis using the SE LHIN CMG profile from their MLPA agreement – a performance agreement that focuses on system performance and financial accountabilities.

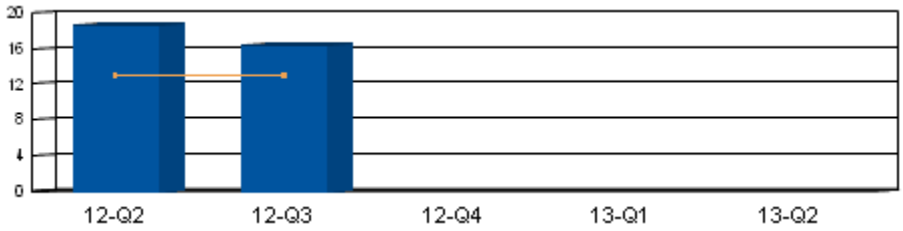
Target: Target 12/13: 18%

MS #07

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

KGH overall average length of stay is better than expected length of stay

Indicator: Readmission Rate Within 30 Days for Selected CMG's to Any Facility *



	Actual	Target
12-Q2	19	**13**
12-Q3	16	**13**
12-Q4		
13-Q1		
13-Q2		

Interpretation - Patient And Business:

30 day readmission rates in part reflects 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 3 quarters behind. The current rate of 16.3 is above 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. It is also worth noting that this indicator is part of the KGH QIP for fiscal 12/13

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: Target 11/12: 12.9%, Target 12/13: 12.9%

Strategy milestone # 8

The Emergency Department wait time for admitted patients is improved by 20%

Strategic Direction	KGH 2015 outcome	Status
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**	**Red**

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

1. **What is our actual performance on each of the indicators for this milestone as listed above?** This milestone is below the target as 9 out of 10 patients are not being admitted to inpatient beds in less than 22 hours…instead 9 out of 10 are admitted within 29 hours, which is an increase from 27 hours in Q1. This performance is however a sustained improvement relative to the target of 31 hours in Fiscal 2012, and also demonstrates the impact of the reduction in the target by 9 hours (30%).

2. **What are the contributing factors to the current performance of the indicators for this milestone?** In Q2 there were repeated instances of having to use Code Gridlock , with durations ranging from 4 hours to approximately 72 hours. The ED experienced an increase in the number of visits and dmissions from ED relative to the past year (9 %). The intermittent surges occurring in medicine, surgery and critical care result in higher numbers and longer stays of inpatients in the ED. These delays in patient flow are also attributed in part to the higher number of ALC patients (36 on average Q2) and number of patients needing to be repatriated (as many as 19 during one Gridlock). The closure of LTCH in Picton appears to be having downstream impact for movement within the LHIN.

3. **Are we on track to meet the milestone by year end?** Not as yet.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** All programs continue with their tactical plans focusing on discharge prediction, consultation and discharge planning processes, Home First education. In addition work on throughput and discharge, there is also work underway to understand the factors with input particularly with the root causes of increase in visits to the ED and increased admissions particularly to Medicine. Discussions with the LHIN and regional partners is ongoing for shared understanding of system pressures and opportunities.

Kingston General Hospital

MS #08

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	G	Y	R	↓
		Percent of ED Consults Meeting Target Time (Time Between Consult Requested in ED and Consultant Arrival ED) *	N/A	N/A	N/A	N/A	N/A	
		Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	G	G	G	G	Y	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

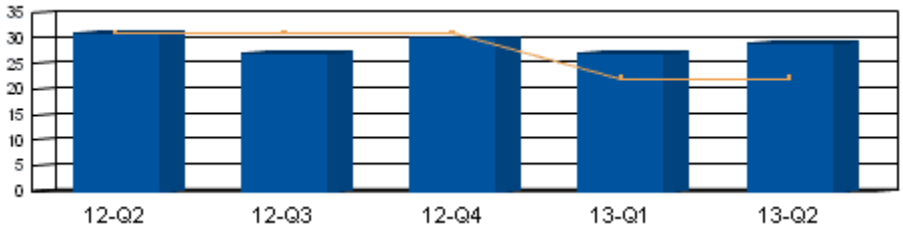
Kingston General Hospital

MS #08

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

The emergency department wait time for admitted patients is improved by 20%

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



	Actual	Target
12-Q2	31	**31**
12-Q3	27	**31**
12-Q4	30	**31**
13-Q1	27	**22**
13-Q2	29	**22**

Interpretation - Patient And Business:

The target of 9/10 patients spending less than 22 hours in the Emergency Department waiting for an inpatient bed has not been met in Q2. Although sustaining improvements made last fiscal, the reduction in the target by 9 hours (30%) along with an increase in the volume of admissions over last fiscal has moved this indicator from green to red. Last year's target of 31 hours was sustained for the whole year.

Total admissions from the ED YTD this fiscal are 441 more than the same time period last fiscal with improved results.

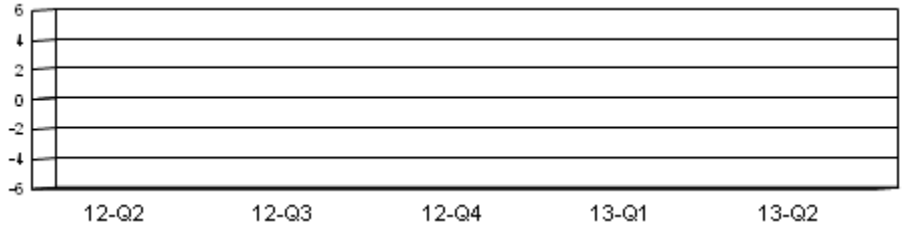
Actions & Monitoring Underway to Improve Performance:

LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning.
LOS is being monitored at a corporate level and discussed at Patient Flow Task Force.
Consultant arrival times are also being monitored from time of consult request to arrival in the ED and time of consult request to disposition decision.
Working with expectation that managers are coming to ED with summary of expected discharges and plans for flow.
Changes with bed assignment process, i.e. Bed Allocator role and reporting/communication tools, continue to be monitored and improved.
Overcapacity beds, flex beds and short stay beds are utilized as appropriate.

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: Target 11/12: 31 Hours, Target 12/13: 22 Hours

Indicator: Percent of ED Consults Meeting Target Time (Time Between Consult Requested in ED and Consultant Arrival ED) *



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1		
13-Q2		

Interpretation - Patient And Business:

Time required for calculation not currently available.

Definition: This indicator is part of the Ministry of Health's (MOH0 Most Responsible Physician (MRP) initiative aimed at meeting the corporate target(s) associated with achieving our ED wait time targets. Within ED wait times, there are many important sub-processes that contribute to the overall wait time. This one focuses the involvement of outside consultants who when asked down to the ED, see the patient, assess the patient, and make a decision as to whether or not to admit the patient.

Target: Target 12/13: 10% Improvement

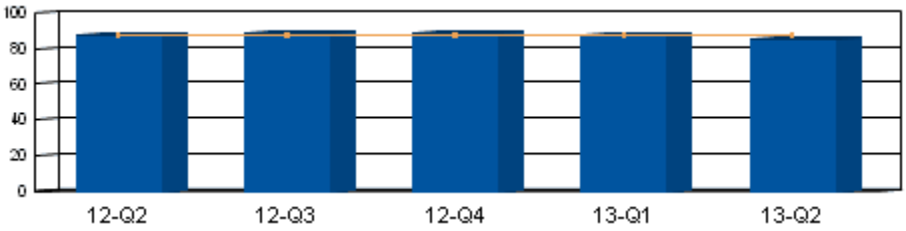
Kingston General Hospital

MS #08

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

The emergency department wait time for admitted patients is improved by 20%

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



	Actual	Target
12-Q2	87	**87**
12-Q3	88	**87**
12-Q4	88	**87**
13-Q1	87	**87**
13-Q2	85	**87**

Interpretation - Patient And Business:

Patient Perspective: Based on the Q2 results, the ED has sustained the improvement in the ED wait time just short of missing the wait time by 2% for non-admitted, high acuity patients.
The target has been sustained with a significant increase in visits in this category.

Volumes for this category of patient acuity increased by 1637 visits over the same quarter last year.

Business Perspective: Year 4 Pay for Results funding enables us to implement initiatives to help with patient flow.

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. We have not been informed yet about targets for 2013 or what the funding will be for this fiscal.

Actions & Monitoring Underway to Improve Performance:

Initiatives are in progress to sustain gains made with respect to this target e.g. improved lab result notification, improvement of 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 with overlapping shifts to cover busier times. A triage transition nurse assignment supports 90 second straight back triage and will help to ensure triage is quick and patients in this category are brought to a stretcher 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. Averages off-load time this quarter is 10 minutes and is the best in the province relative to peer hospitals.

Color coding on EDIS alerts staff if patients are approaching target time.

We had been green in the previous 5 quarters but saw significantly more volumes in Q2 - 343 more visits than in Q1.

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% Target 12/13: 87%

Strategy milestone # 9

Clinical services meet the provincial wait time target

Strategic Direction	KGH 2015 outcome	Status
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**	**Yellow**

Indicator
Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (excluding Cancer Surgery)

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   83% (39 of 47) of the clinical services are meeting the 90th percentile wait times improved from 65% in Q1.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Bed resources and patient flow continue to be the biggest challenges in meeting wait time and volume targets.

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

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

   SPA leadership and the Wait Times Committee continue their focus on monitoring activity. Daily patient flow initiatives via the Patient Flow Committee and Discharge project hope to improve access.

Kingston General Hospital

MS #09

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
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	Orthopedic Surgery (Excluding Total Hip and Knee Replacements) - 90th Percentile Wait Time (Days)	R	R	R	R	Y	
		Diagnostic Imaging- MRI – 90th Percentile Wait Time (Days)	R	R	R	R	R	
	Clinical services meet the provincial wait time target	Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	R	R	R	Y	R	
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	R	R	R	R	Y	
		Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	
		Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	
		Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs	Y	G	Y	G	Y	
		Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th Percentile Wait Time (Hrs)	R	R	R	R	R	
		All Paediatric Surgery - 90th Percentile Wait Time (Days)	R	R	R	G	Y	
		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 (Days)	G	G	G	G	G	
		Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)	G	G	G	G	G	
		General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	G	R	R	R	Y	
		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	R	R	Y	

	12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Percent of Wait Time Contracted Volumes Achieved	Y	Y	Y	R	R	↓
Radiation Wait time (Referral-Consult) Percent Seen Within 14 Days	R	R	R	R	N/A	↓

Indicates improving performance to target over the past 5 quarters ↑

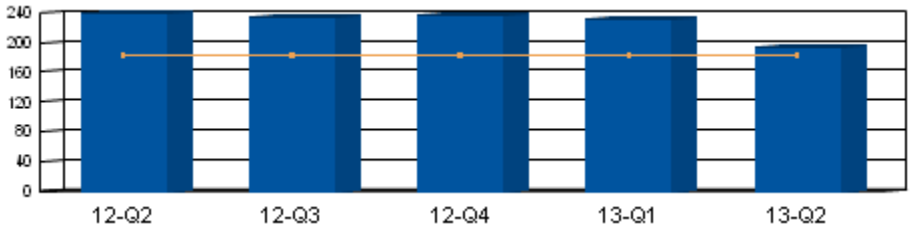
Indicates worsening performance to target over the past 5 quarters ↓

MS #09

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

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

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



	Actual	Target
12-Q2	240	**182**
12-Q3	235	**182**
12-Q4	237	**182**
13-Q1	232	**182**
13-Q2	193	**182**

Interpretation - Patient And Business:

This KPI for the second quarter reflects an ongoing positive trend with continued decreasing days to meet the target. There were 275 cases completed in this quarter with 3 cases having accumulated wait times between 424 to 1091 days. The 90 % wait time in days in July was 243 days decreasing to 158 days in September. The median also is trending more positively with 63 days in July transitioning to 55 days in September.

Actions & Monitoring Underway to Improve Performance:

Wait times are monitored at the joint KGH/HDH Wait list committee meetings. Additional ortho trauma operative time allocated on weekends to KGH wait times continue to support improvement. In addition SPA Program leadership has provided additional resources to support office staff with the monitoring of their wait time lists.

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.

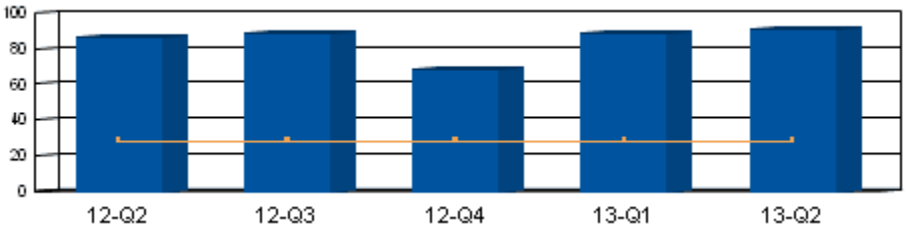
Target: Baseline 08/09: 183 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days.

MS #09

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
12-Q2	86	**28**
12-Q3	88	**28**
12-Q4	68	**28**
13-Q1	88	**28**
13-Q2	91	**28**

Interpretation - Patient And Business:

Meeting the wait times for MRI continues to be challenging. With only a single hospital based magnet the demand far out reaches the available resources. Constant effort is applied to MRI to increase efficiency by improving booking practices, improving protocols, balancing staffing and upgrading software applications on the magnet.

Decreasing the wait times requires constant attention and reaching the provincial target of 28 day will be impossible due to the number of referrals every month, however improvement should be seen over the next 2 quarters with a goal of achieving 72 days by the end of Q4.

Actions & Monitoring Underway to Improve Performance:

Wait times for MRI has a direct impact on patient care. Ordering physicians must wait for results. the patient's stress is increased as they wait long periods of time to access the service. Nearly all non-specialized MRI work is referred to the private clinic allowing the KGH magnet to concentrate on the complex specialized MRI procedures.

A business plan has been developed for a second hospital based MRI. This is being presented to the LHIN and MOH. If approved the next steps will include fundraising and organizing for capital and operational funds for a second magnet. However this is a long-term plan that would at minimum take at least 2 years to reach fruition.

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.

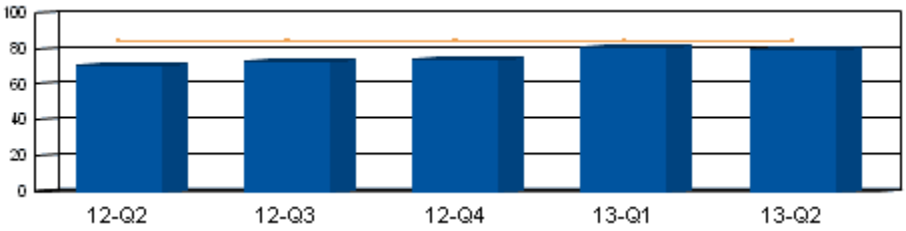
Target: Baseline 08/09: 120 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days Target 12/13: 28 Days

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	71	**84**
12-Q3	73	**84**
12-Q4	74	**84**
13-Q1	81	**84**
13-Q2	79	**84**

Interpretation - Patient And Business:

Patient Perspective: Based on Q2 results the ED is below the ED target wait time for percent of patients CTAS 4 and 5 discharged within 4 hours. This indicator has improved over last fiscal with increased volumes. Q2 result is trending negative compared to Q1 by 2% with an increase of 305 visits in this category and 957 overall. Inpatient days in ED were also up this quarter at 1062 with August hitting a high of 406 inpatient days.
Patients in this category will wait longer in the waiting room when the department is above capacity to allow more urgent patients to be seen and assessed.

Business Perspective:
High volumes of patients with higher acuity means that patients in this category wait longer for physician assessment, diagnosis and treatment.

Actions & Monitoring Underway to Improve Performance:

An increase in higher acuity volumes combined with the number of admitted patients waiting for beds has forced more patients to wait in the waiting room for a space to become available for further assessment and treatment.
Section B is being utilized as a fast track area but sometimes these beds are not readily available as they are used for procedures, mental health assessments and overflow when the department is busy.
The Emergency Program Council continues to look for ways to redesign flow within the department to continue to move toward target with a focus on optimizing stretcher use and reducing time to initiation of investigations. Prinicipals of a rapid assessment zone will be trialed for this patient population.

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

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

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

Target: Baseline 08/09: 66%, Target 09/10: 76%, Target 10/11: 84%, Target 11/12: 84%. Target 12/13: 84%

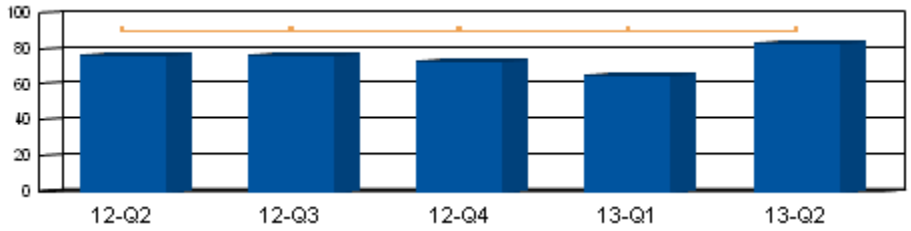
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)



	Actual	Target
12-Q2	76	**90**
12-Q3	76	**90**
12-Q4	73	**90**
13-Q1	65	**90**
13-Q2	83	**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.

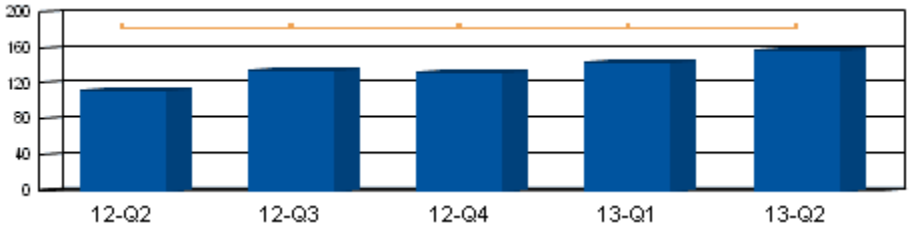
Actions & Monitoring Underway to Improve Performance:

The Q2 results indicate that the target of 90% has still not been reached. Q2 results show that 43 of 52 (83%) of publically reported wait times meet the 90th percentile wait time target. As of Q2, 1 procedure category in General Surgery, 2 in plastic surgery, and 1 in Urology, 4 in Gynecology, and the MRI wait time. The 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: FY2013 includes all surgical wait time categories reportable to the Wait Times Information System. This excludes Ophthalmic, Otolaryngic and Cancer surgery. Diagnostic Imaging: MRI and CT are also included.

Target: Target 12/13: 90%

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



	Actual	Target
12-Q2	111	**182**
12-Q3	135	**182**
12-Q4	132	**182**
13-Q1	144	**182**
13-Q2	156	**182**

Interpretation - Patient And Business:

This KPI indicator continues to maintain its green target status. The median days waiting started at 70 days for the quarter decreasing to 62 days in September. The 90% percentile wait time in July was 169 days decreasing to 104 days in September Access to additional operating room time in the evenings (Mon, Wed, Thurs, Fri) as well as weekends (2 additional OR's resourced) continues to assist in keeping this indicator within the target range.

Actions & Monitoring Underway to Improve Performance:

Constant monitoring of additional ortho trauma time during the weekday is being conducted by program management and the Wait Time committee. Opportunity to add additional ortho elective cases during unutilized general emergency time or ortho trauma operating is being implemented.

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. Target 12/13: 182 Days

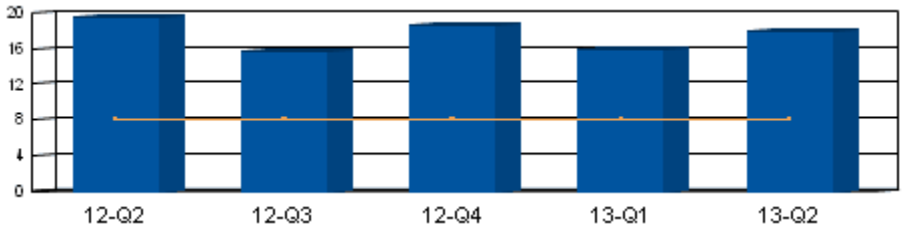
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	19.6	**8**
12-Q3	15.7	**8**
12-Q4	18.7	**8**
13-Q1	15.9	**8**
13-Q2	17.9	**8**

Interpretation - Patient And Business:

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, continuous improvement projects to improve LOS and gain efficiencies through eliminating non-value added activity.

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

A drop in weekend discharges contributes to a bottleneck in the 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 the ED longer than 8 hours meaning the breach occurs before the time of conversion from outpatient to inpatient. This often occurs when consults are not done in a timely fashion or there is a delay in the decision to admit. Consult times are now being tracked at 2 time stamps: time from consult request (or from when a patient arrives as direct to service) to the arrival of consultant service is the first time stamp and time from consult request to disposition decision is the second.
Additional flex beds were opened to help manage higher volumes. The funding for these beds comes from the provincial Pay for Results program and funding is at risk of claw back if targets are not met. We have not been informed about funding for Pay for Results for this fiscal. The express beds and numerous positions supporting patient flow are at risk without funding which would have a negative impact on patient flow.

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. Target 12/13: 8hrs

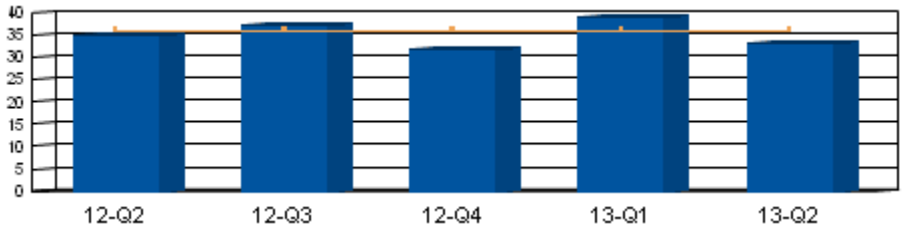
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs



	Actual	Target
12-Q2	35	**36**
12-Q3	37	**36**
12-Q4	32	**36**
13-Q1	39	**36**
13-Q2	33	**36**

Interpretation - Patient And Business:

Patient Perspective: Based on Q2 results, we are failing to meet this target by 3% which is equal to 80 patients. While many patients (1798) waited longer than 8 hours before reaching their inpatient bed, 36% (966 patients) moved within the 8 hour target.
Inpatient days in ED this quarter were 1071days which is 228 days more than the previous quarter.

Business Perspective: When the ED is backed up with patients waiting for an inpatient bed 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, limits the ability to quickly move these patients to an inpatient bed if these specialized beds are not available.

Funding from the provincial Pay for Results program will enable us to continue with initiatives in place to sustain gains made and continue to improve patient flow. This target and funding for this fiscal are unknown at this time.

Actions & Monitoring Underway to Improve Performance:

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 as well as the time from consultant request to disposition decision is now being measured, monitored, and reported.

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.

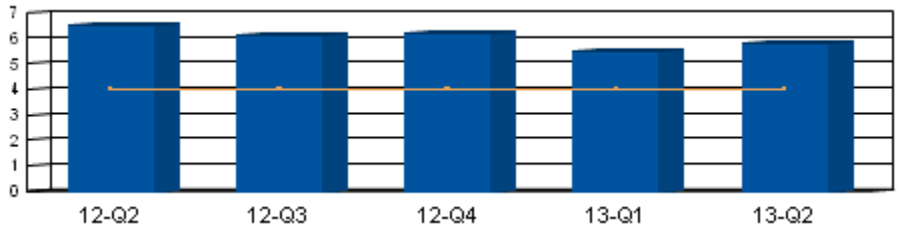
Target: Baseline 08/09: 27%, Target 09/10: 37%, Target 10/11: 36%, Target 11/12: 36%. Target 12/13: 36%

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th Percentile Wait Time (Hrs)



	Actual	Target
12-Q2	6.5	**4**
12-Q3	6.1	**4**
12-Q4	6.2	**4**
13-Q1	5.5	**4**
13-Q2	5.8	**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 4 hours for patients presenting with minor or uncomplicated conditions. Ten percent of patients in this category had a total length of stay longer than 5.5 hours. The ability to see patients in this category is dependent on available assessment space. With the increase in admitted patients and a significant increase in higher acuity patients, these patients tend to wait longer.

Business Perspective: This is an indicator in the provincial Pay for Results program with a target of 4:52 hours at the 90th percentile. Funding is at risk of claw back if targets are not met.

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. Efforts are made to move this patient population through the fast track area quickly; however, due to increase in volumes of higher acuity patients, it is sometimes necessary to use the rooms in this section for sicker patients who stay longer.

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

The program is working on a project using lean methodology to optimize the use of stretchers and the use chairs, when appropriate, to create capacity.

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. Target 12/13: 4hrs

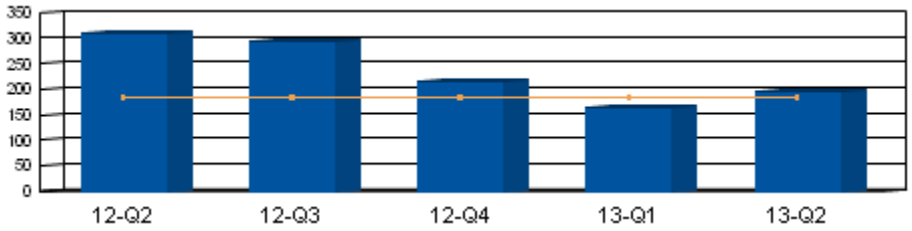
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	310	**182**
12-Q3	293	**182**
12-Q4	217	**182**
13-Q1	164	**182**
13-Q2	195	**182**

Interpretation - Patient And Business:

The slight increase in the overall 90% percentile for this quarter of 31 days is strongly influenced by increased corporate activity resulting in OR cancellations for this service as well as the resignation of a pediatric general surgeon. The breakdown of wait times for each service for the pediatric population is the following:

General Surgery (2 cases)

90% percentile for July was 103 days for two cases.

ENT

90% percentile has decreased from 252 days in July to 226 days in September with the median wait in July of 72 days slightly increasing to 80 days in September

Urology (smaller case volumes (10 cases)

90% percentile has decreased from 104 days in July to 6 days in September with an average median of 52 days in July decreasing to 6 days at the end of the quarter.

Actions & Monitoring Underway to Improve Performance:

Efforts are underway to review the recruitment process for a second pediatric surgeon. Service is encouraged to access extra available general emergency time to assist with increasing operative time lost with cancellations.

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. Target 12/13: 182 days

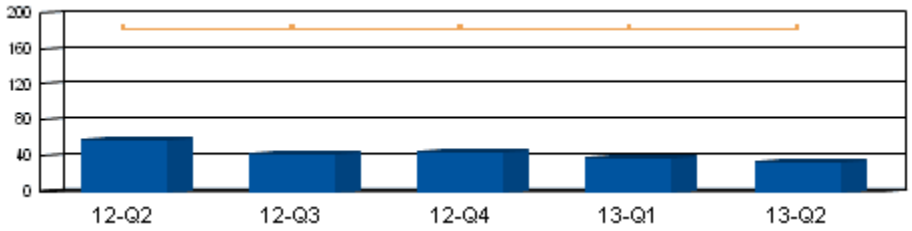
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	57	**182**
12-Q3	43	**182**
12-Q4	45	**182**
13-Q1	37	**182**
13-Q2	33	**182**

Interpretation - Patient And Business:

Patient Perspective: Based on Q2 activity, KGH is meeting the performance target for elective cardiac bypass surgery wait times. Wait time at the 90th percentile is 33 days which is 57 days below the provincial target of 90 days for elective CABG. 100% of all elective cases were completed within the recommended maximum wait time of 90days. The median wait time was 13 days. Patients are not waiting beyond the RMWT for cardiac bypass surgery at KGH.

Business Perspective: A more coordinated approach to monitoring and scheduling cardiac bypass surgery has been beneficial with respect to increasing access to care and maintaining wait times. Streamlining the work of the Regional Cardiac Care Coordinators so that one coordinator has assumed primary responsibility for surgery will enhance the service at KGH.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac surgery monitors wait lists daily and books patients according to a pre-defined urgency rating scale. Patients are given the option of being referred to another center outside of the LHIN if KGH cannot complete their surgery within the target wait time. If a delay is identified, it is followed-up by the RCCC.

There are no concerns at the time with wait times for any urgency. The wait list is relatively short which sometimes makes it difficult to book patients for surgery. From the time of decision the patient needs to be seen in pre-surgical screening clinic which is sometimes difficult to arrange on short notice. We are working with HDH to resolve.

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.

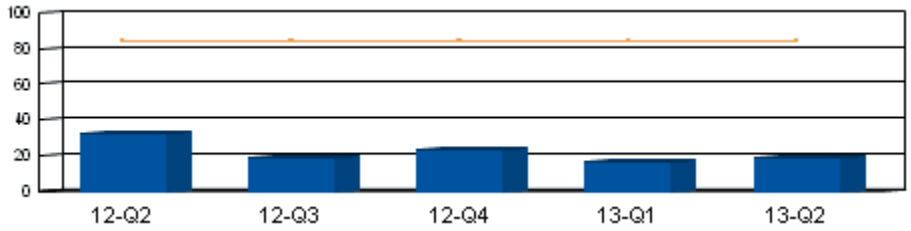
Target: Baseline 08/09: 78 days, Target 09/10: 182 days, Target 10/11: 182 days, Target 11/12: 182 days Target 12/13: 182 Days

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	32	**84**
12-Q3	19	**84**
12-Q4	23	**84**
13-Q1	17	**84**
13-Q2	19	**84**

Interpretation - Patient And Business:

Patient Perspective: Based on Q2 activity, KGH is meeting the wait time target for cardiac angiography. Wait time for elective angiography is 19 days at the 90th percentile. This is 65 days below the provincial target. 100% of patients had their elective angiogram within the recommended wait time. The median wait time for elective angiography was 12.6 days.

Business Perspective: Completing procedures within the target wait time helps KGH stay on target for completing funded volumes and helps to avoid the cost inefficiencies associated with longer wait times including inpatient LOS.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac cath monitors wait lists daily and books patients according to urgency rating. All patients in the region are booked for procedures based on this urgency rating.

Close attention is paid to ensuring we are serving the regional hospitals and patients across the LHIN in an equitable manner. This is achieved in part through the same day program and the STEMI By-pass protocol.

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 interventionalists, 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. Target 12/13: 84 Days

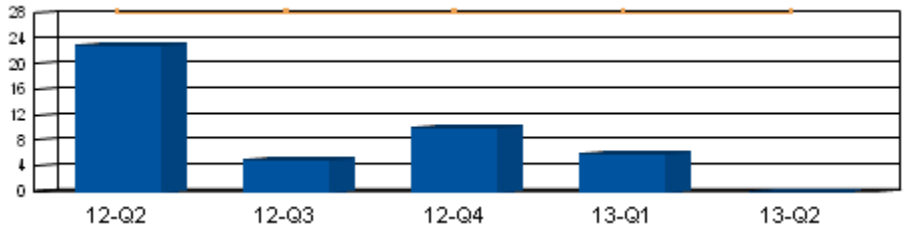
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	23	**28**
12-Q3	5	**28**
12-Q4	10	**28**
13-Q1	6	**28**
13-Q2	0	**28**

Interpretation - Patient And Business:

Patient Perspective: Based on Q2 activity, KGH is exceeding the wait time target for coronary angioplasty. The wait time at the 90th percentile is 0 days which is 28 days below the provincial target. The median for elective PCI in Q2 averages 0 days. 100% of all patients are completed with the recommended wait time for all urgency ratings.

Business Perspective: Completing all procedures within the target wait time helps KGH stay on target for completing additional funded volumes and helps to avoid the cost inefficiencies associated with longer wait times.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac cath monitors wait lists daily and books patients according to urgency rating. Many angioplasties occur as same sitting PCI which means diagnostic angiograms are followed by angioplasty in one procedure. The number of same sitting PCIs done at KGH is just at the provincial average. This results in one lab time for the patient rather than 2 separate procedures booked at 2 different times.

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. Target 12/13: 28 Days

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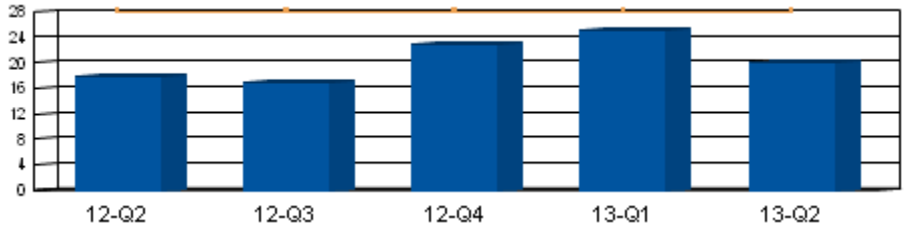
Indicator: Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)



	Actual	Target
12-Q2	18	**28**
12-Q3	17	**28**
12-Q4	23	**28**
13-Q1	25	**28**
13-Q2	20	**28**

Interpretation - Patient And Business:

KGH continues to stay well below the provincial average. The LHIN based target is considerably more aggressive with a target number of 15 days. We continue to strive to meet the LHIN target and expect to by Q4. Meeting this target ensures exemplary service for the patients and the programs that depend on CT.

Actions & Monitoring Underway to Improve Performance:

Continue to monitor monthly.

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. Target 12/13: 28 Days

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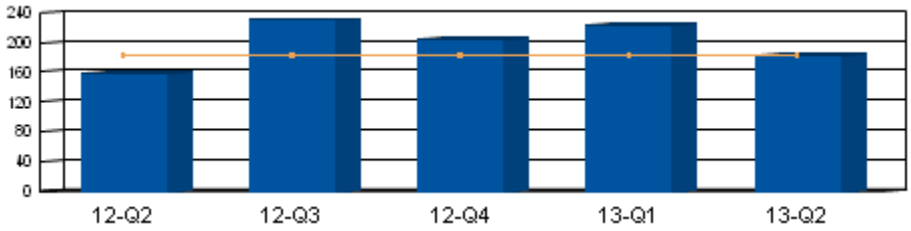
MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	159	**182**
12-Q3	230	**182**
12-Q4	204	**182**
13-Q1	223	**182**
13-Q2	183	**182**

Interpretation - Patient And Business:

For this quarter better management of wait time lists and continued access to additional OR time during the evening and on weekends to add any elective cases have positively contributed to improvements in achieving the provincial target of 182 days.

The 90% wait times have increased slightly from155 days in July to 172 days in September with a positive trending in median times of 85 days in July to 72 days in September. Contributing to the increase in the 90% wait time is the completion of 6 cases averaging from 300 to 411 days waiting in this quarter.

Actions & Monitoring Underway to Improve Performance:

Continued monitoring between 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. Target 12/13: 182 Days

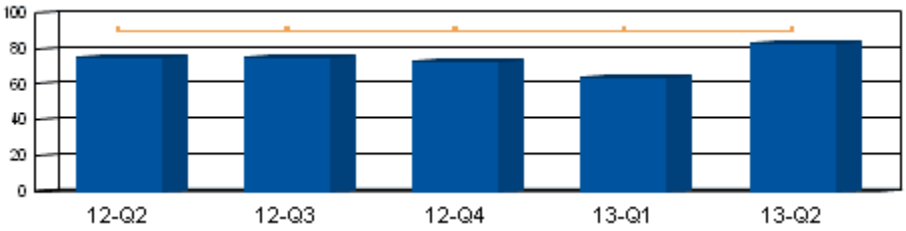
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q2	75	**90**
12-Q3	75	**90**
12-Q4	73	**90**
13-Q1	64	**90**
13-Q2	83	**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. Q2 results show that 39 of 47 (83%) of publically reported surgical wait times meet the 90th percentile wait time target. As of Q2, 1 procedure category in General Surgery, 2 in plastic surgery, and 1 in Urology, and 4 in Gynecology 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% Target 12/13: 90%

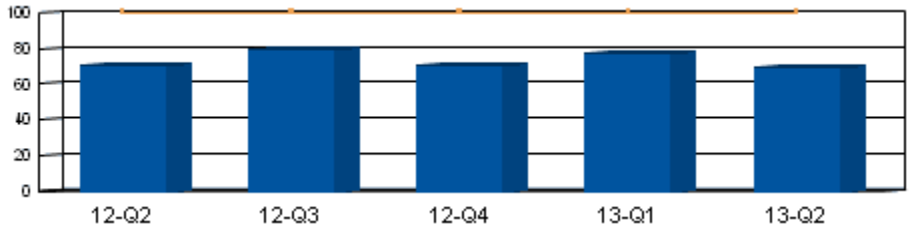
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
12-Q2	70	**100**
12-Q3	80	**100**
12-Q4	70	**100**
13-Q1	77	**100**
13-Q2	69	**100**

Interpretation - Patient And Business:

As of Q2 there were 4 incremental volume contracts that were not on target (gallbladders, ventral hernia, ped dental, and ped ACL repair).

Actions & Monitoring Underway to Improve Performance:

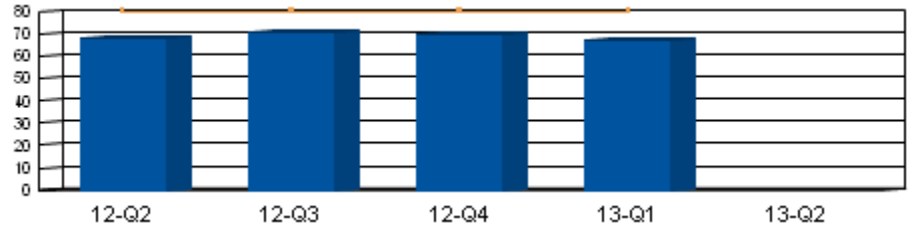
The Wait List Management Committee and the Surgical Program closely monitoring these issues.

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 F2013: Anorectal,Gall Bladder, Intestinal IP, Groin Hernia, Ventral Hernia,Paediatric Oral Maxiofascial (Dental) OP, Paediatric Scoliosis,, Paediatric Cleft Lip, Paediatric ACL, MRI, CT,Cancer Surgery, Cardiac (includes Angioplasty, Angiography,Bipass Surgery).

Target: Target 11/12: 100% Target 12/13: 100%

Indicator: Radiation Wait time (Referral-Consult) Percent Seen Within 14 Days



	Actual	Target
12-Q2	68	**80**
12-Q3	71	**80**
12-Q4	70	**80**
13-Q1	67	**80**
13-Q2		

Interpretation - Patient And Business:

Data for Q2 Not Expected Until November 15

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%. Target 12/13: 80%

Strategy milestone # 10

Cancer Care Ontario access to care indicators are met

Strategic Direction	KGH 2015 outcome	Status
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**	**Red**

Indicator
Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The Q1 data indicates that 3 of the 4 CCO indicators currently do not meet the established target (Q2 results imminent). These include: radiation therapy wait time (referral to consult); systemic therapy wait time (consult to treatment) and system therapy wait time (referral to consult). The one indicator meeting the target is the radiation consult to treatment wait time which performed at 100% of patients treated within the priority access target (1st of 14 in the province). This success is attributed to continuous real time data monitoring on a patient level basis by the radiation therapists. Wait time access indicators for initial consultation with a radiation or medical oncologist are underperforming.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Challenge with meeting the targets is multifactorial for both radiation and oncology. There are some shared process problems linked to how referrals are received and triaged. Vacancies with medical oncologists further challenge capacity to deal with referrals.

3. **Are we on track to meet the milestone by year end?** Not as yet

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** The program is introducing the necessary rigour with oversight and continuous improvement. The program is auditing cases that exceed the target each month to assess cause of avoidable delays. To address the unmet chemotherapy and radiation wait times, improvement teams have been established to design and implement tactics that will be overseen by the Cancer Care program leadership and reported to KGH and CCO. Attention will be given to registration and booking processes for new patient referrals to the centre and improvements in the accuracy of data. As well recruitment and design of new models of care are underway but will not be quick solutions.

Kingston General Hospital

MS #10

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	Cancer Care Ontario access to care indicators are met	Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)	R	R	R	R	N/A	↓
		Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met	R	R	R	R	R	↑
		All Cancer Surgery Wait Time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑

↑ Indicates improving performance to target over the past 5 quarters

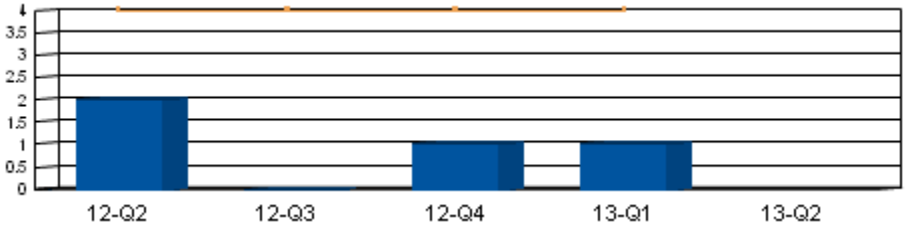
↓ Indicates worsening performance to target over the past 5 quarters

MS #10

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

Cancer Care Ontario access to care indicators are met

Indicator: Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)



	Actual	Target
12-Q2	2	**4**
12-Q3	0	**4**
12-Q4	1	**4**
13-Q1	1	**4**
13-Q2		

Interpretation - Patient And Business:

Data for Q2 Not Expected Until November 15

Actions & Monitoring Underway to Improve Performance:

Data for Q2 Not Expected Until November 15

Access to care indicators are closely monitored as part of the KGH and Cancer Care Ontario performance scorecards and quarterly review processes.

Given KGH's role as a tertiary cancer care provider for the South East region, it is important that considerable effort be made to understand the barriers to meeting the Cancer Care Ontario Access to Care indicators.

Focused improvement initiatives are being launched in Q3 to address any data quality, capacity, process or accountability issues impacting on KGH's ability to meet these targets. Cancer Program clinical and operational leaders are overseeing these initiatives and will be reporting on progress through KGH's and CCO's Quarterly Review mechanism.

Definition: Cancer Care Ontario reports on wait times for access to both systemic (IV chemotherapy) and radiation therapy. Systemic access is measured according to the interval referral to consult (14-day target), and consult to treatment (28-day target). Radiation access is measured according to the interval from referral to consult (14-day target), and the time between being ready for treatment and receiving treatment (1, 7, or 14 day target for priorities 1, 2, and 3, respectively). CCO measures the percent of patients who were treated within their respective access targets. This indicator is a roll-up of the four access to care contract indicators met.

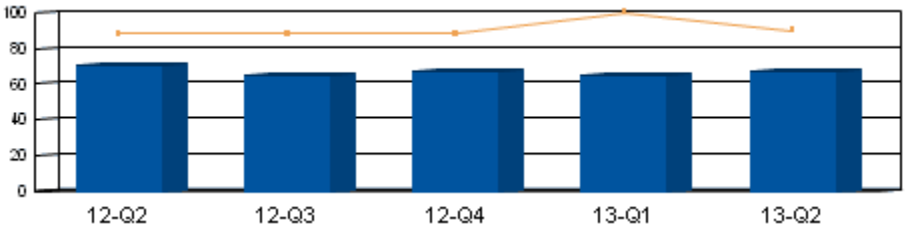
Target: Target 4

MS #10

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

Cancer Care Ontario access to care indicators are met

Indicator: Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met



	Actual	Target
12-Q2	70	**88**
12-Q3	65	**88**
12-Q4	67	**88**
13-Q1	65	**100**
13-Q2	67	**100**

Interpretation - Patient And Business:

Based on Q2 results, KGH is not meeting the established Cancer Care Ontario (CCO) target for access to cancer surgery.

Actions & Monitoring Underway to Improve Performance:

KGH has not been meeting the CCO target for the past number of 6 quarters. In response to this, an improvement project has been launched to drive changes that move KGH to achieving the established target and reducing the overall wait time for cancer surgery. This project is jointly managed by the Cancer Program, SPA and KGH Decision Support.

The improvement strategy includes a weekly review of KGH data relating to:

1. Number of patients who have exceeded the wait time associated with the priority assigned to their case;
2. Length of time they have been waiting beyond the assigned target;
3. Type of cases waiting by disease site and surgeon;
4. Utilization of emergency slots available for cancer surgery cases
5. Priority coding practices for cancer surgery cases.

Using this information, close interaction occurs with surgeon's offices to determine what action is required to enable the patient access to treatment as quickly as possible. Action is taken based on this assessment.

Other aspects of the improvement project include addressing data quality issues and assessing overall resources utilization dedicated to cancer surgery.

Definition: Surgical wait times are measured by tracking the time between when a surgeon decides to operate and when the surgery takes place. The priority of the case, determined by the surgeon, depends on many factors such as the type of cancer, patient complexity and progression of the disease. This access indicator measures the percent of patients who meet their priority access targets (2, 3, or 4), from the date of decision to treat until surgery date, for those aged 18 and older, undergoing treatment-intent oncology surgery for all disease sites except for skin and lymphoma.

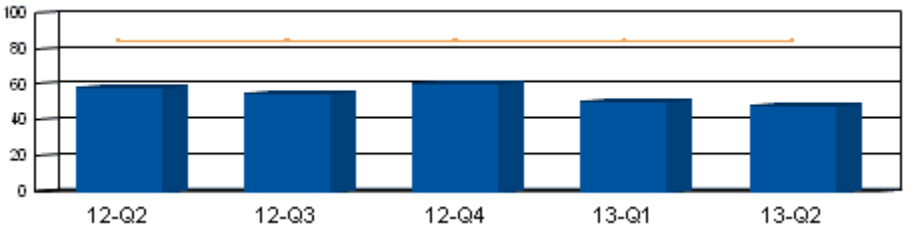
Target: Target 100%

MS #10

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

Cancer Care Ontario access to care indicators are met

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



	Actual	Target
12-Q2	58	**84**
12-Q3	55	**84**
12-Q4	60	**84**
13-Q1	50	**84**
13-Q2	48	**84**

Interpretation - Patient And Business:

The KGH 90th percentile wait continues to better than the provincial target in days waiting.

The following are updates of key procedures:

Urology: 90th percentile wait has decreased by 15 days for this quarter. The median wait in September of 40 days continues to trend positively from 53 days in July. Overall the trending continues to be positive and efforts for further improvement are being monitored.

Gynecology - 90th percentile wait in September is 29 days down from 69 days in July. The median wait for this quarter continued to trend positively downwards starting at 35 days in July to 29 days in September.

Actions & Monitoring Underway to Improve Performance:

The SPA program leadership will continue to support central management of Oncology time with the continuation of extended operating days and extra booked cases. This initiative is proving to be effective in managing the wait list and providing patients with more timely service.

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.

Strategy milestone # 11

Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)

Strategic Direction	KGH 2015 outcome	Status
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**	**N/A**

Indicator
Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project

1. **What is our actual performance on each of the indicators for this milestone as listed above?** This milestone has been put on hold pending decision regarding change in the IT platform at KGH.

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

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** It is expected that a corporate decision regarding the IT platform will be made by Summer 2013. In the interim, work continues on the hard copy elements of an interprofessional assessment tool and adverse reaction document with the view that these would become automated at a future date.

Kingston General Hospital

MS #11

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
Bring to life new models of interprofessional care and education	Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)	Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Indicates improving performance to target over the past 5 quarters

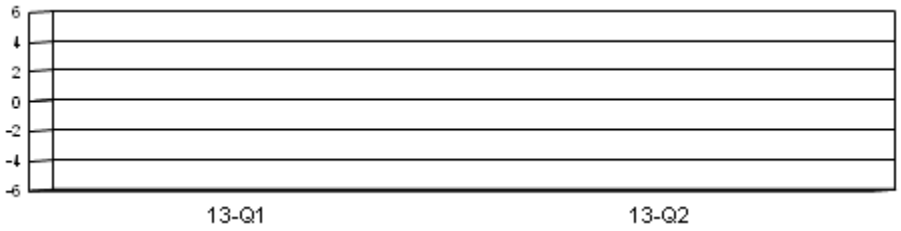
Indicates worsening performance to target over the past 5 quarters

MS #11

Bring to life new models of interprofessional care and education

Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)

Indicator: Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project



	Actual	Target
13-Q1		
13-Q2		

Interpretation - Patient And Business:

Project is on hold and will be proceeding to board for decision regarding timelines.

Definition: As part of transitioning to a fully automated patient record, and in support of interprofessional document as an underpinning of communication amongst providers, the electronic documentation (e-doc) project is being extended to include automation of interprofessional assessment and adverse reaction documents. This component of the project necessitates development of content for the documents and translation of that content into an electronic format, as well as change in practice of providers with documentation practices.

Target: Target 100%

Strategy milestone # 12

Workplan to fulfill interprofessional education competencies completed

Strategic Direction	KGH 2015 outcome	Status
Bring to life new models of interprofessional care and education	**KGH is recognized as a centre of excellence in interprofessional education**	**Yellow**

Indicator
Number of Interprofessional Organizational Educational Competencies Are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The detailed action plan has not been through the final step of approval; however there is progress being made on activities aligned to the plan with anticipation that the plan will be endorsed by the IPE Steering Committee in Q3 and actions will be accomplished by March 2013.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Progress made in Q2 relates to the redesign of the IPE Steering Committee with a smaller and more focused membership. Terms of Reference were approved by EMC and the first meeting is scheduled in late November. A draft communication strategy was received from the Communications team in October and will be discussed at the November meeting. In the interim, communications has supported messaging in KGH This Week and includes references to IPE when appropriate in the profile of corporate activities (Accreditation, ICPM role reviews, and KGH Community Showcase) . As well a session was held in September taking stock of opportunities for alignment of PFCC, ICPM and IPE in support of transforming the patient experience.

3. **Are we on track to meet the milestone by year end?** Yes with concerted effort on IPE initiatives and support with communication and profile. Major IPE corporate events being planned include the KGH Community Showcase in Jan 2013 and the Patient Experience Conference in May 2013.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Building upon a discussion with Dean Reznick, Vice Dean, Health Education Flynn, and KGH Leadership (LJT and ER), there is plan to bring an external expert (Maria Tassone, IPE Lead UHN) to assess current practices and activities and offer recommendations about potential and shared opportunities for collaboration between KGH and Queen's that build on the respective IPE strategies.

MS #12

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
Bring to life new models of interprofessional care and education	Workplan to fulfill interprofessional-education competencies is completed	Number of Interprofessional Organizational Educational Competencies Are Met	N/A	N/A	N/A	R	Y

Indicates improving performance to target over the past 5 quarters

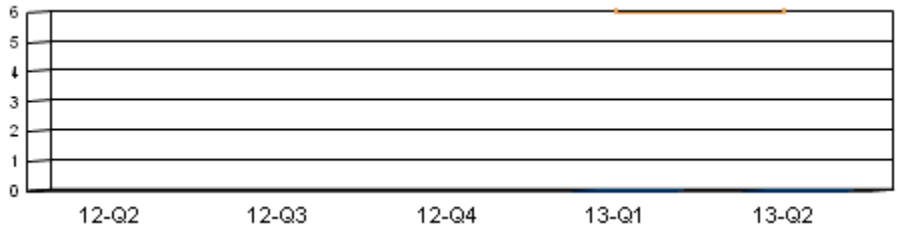
Indicates worsening performance to target over the past 5 quarters

MS #12

Bring to life new models of interprofessional care and education

Workplan to fulfill interprofessional-education competencies is completed

Indicator: Number of Interprofessional Organizational Educational Competencies Are Met



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	0	**6**
13-Q2	0	**6**

Interpretation - Patient And Business:

The organizational accountabilities related to educating professional staff is progressing and timelines for Q2 have been achieved. There is progress on 5 of the competencies and a detailed action plan is being finalized. A number of challenges that were identified including the design of the Steering Committee, communication resources and competing priorities for the resources available have limited the messaging about IPE in the organization. Specific steps are being taken to address these challenges and include: assigning a newly recruited communications staff to the project; more deliberate alignment of the IPE work to that of ICPM and patient & family-centred care initiatives; revision of the IPE Steering Committee membership to a smaller team; and work with Queen's University to leverage the work being done with the strategic framework of the Faculty of Health Sciences.

Actions & Monitoring Underway to Improve Performance:

There is an appreciation that additional steps have been taken to improve the project design, to heighten organizational awareness of IPE activities and to better engage staff to assist in realizing the goal for this year and the 2015 outcome. It is expected these steps will help to profile work that has already been done, and will also improve the likelihood of engaging IPE champions and staff to further the work associated with the action plans. Both outcomes will enable success in KGH demonstrating evidence of the organizational competencies.

Definition: There are 10 organizational accountabilities related to educating professional staff. The accountabilities are viewed through the lens of staff continuing education & professional development, as well as the student learning experience.

Performance will be measured by degree of completion of the work plan, which includes activities, timelines and deliverables that addresses the 10 interprofessional education accountabilities.

Target: 2012/2013 Target: 6

Strategy milestone # 13

Clinical research space at KGH increases by 25%.

Strategic Direction	KGH 2015 outcome	Status
Cultivate patient oriented research	**Externally funded research at KGH has increased by 50%**	**Green**

Indicator(s)
Square Footage of Clinical Research Space at KGH
8% Increase of Externally Funded Research Dollars at KGH

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The pulmonary function lab has been committed as research space for Dr. Alberto Neder. Preliminary structural plans for a clinical investigation unit on Connell 4 have been developed. Survey of services/facilities required by users is in progress.

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

3. **Are we on track to meet the milestone by year end?**
   On track with respect to identification and commitment of space. Space potentially useable but suboptimal. Fund raising has begun and first commitment of funds received (Robinson Foundation $75k). Awaiting decision from Henderson foundation.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Case for fund raising for CIU has been completed. CIU has been confirmed as a priority for UHKF. Chair for fundraising has been identified and confirmed.

Kingston General Hospital

MS #13

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	8% Increase of Externally Funded Research Dollars at KGH	G	G	G	N/A	G	↑
		Square Footage of Clinical Research Space at KGH	N/A	N/A	N/A	N/A	N/A	
		Active Clinical Trials	G	G	G	G	G	↑
		New Clinical Trials	R	R	G	R	R	↑
		Clinical Trials Generating Revenue	G	G	G	G	G	↑

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

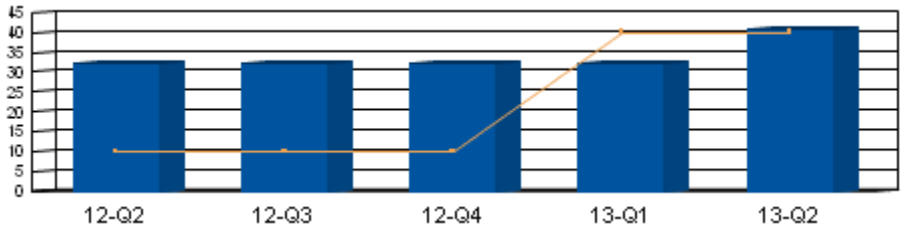
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: 8% Increase of Externally Funded Research Dollars at KGH



	Actual	Target
12-Q2	32	**10**
12-Q3	32	**10**
12-Q4	32	**10**
13-Q1	32	**40**
13-Q2	41	**40**

Interpretation - Patient And Business:

KGH Research Annual Report will be released in fall 2012 and the data for percent increase in research funds will be recorded in Q2/Q3. Real F2012 data will be used for reporting of F2013 data for this performance indicator since real figures for F2013 will not be available until September 2013. 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 M, $16.3 M, and $21.6 M in external funding from government sources, foundations, societies and agencies, industry, and other sources in F2009 (baseline), F2010, and F2011 respectively. Our 2015 Target is $23.5 M. Real F2012 data will be used for reporting of F2013 data for this performance indicator since real figures for F2013 will not be available until September 2013. 95% of the data is obtained from external sources and is not available on a quarterly basis for reporting.

Target: 2012/2013 Target: 40%

Indicator: Square Footage of Clinical Research Space at KGH

	Actual	Target
13-Q1		**52500**
13-Q2		**52500**

Interpretation - Patient And Business:

Complete turnover of Connell 4 to KGHRI expected to occur in early 2013. Currently only three offices are occupied by KGHRI within the wing.

Definition: Current square footage for research space at KGH is ~42,000 sq/ft. Ongoing plans to increase research space during F2013 by 25 percent are under development. Potential space on Connell 4 has been identified that will provide the majority of space (~8,500 sq/ft). Additional space (~3,000 sq/ft) has been identified on Angada 0. Occupancy of both areas will help us meet this performance indicator however they are dependent on the current occupants vacating the area in the coming fiscal year to remain on target.

Target: 2012/2013 Target 52,500 sq/ft

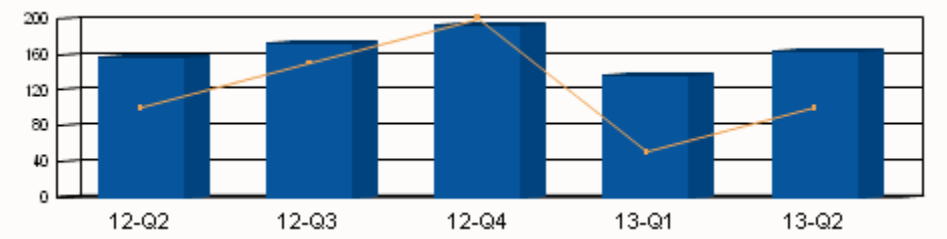
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Active Clinical Trials



	Actual	Target
12-Q2	157	**100**
12-Q3	172	**150**
12-Q4	192	**200**
13-Q1	136	**50**
13-Q2	163	**100**

Interpretation - Patient And Business:

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

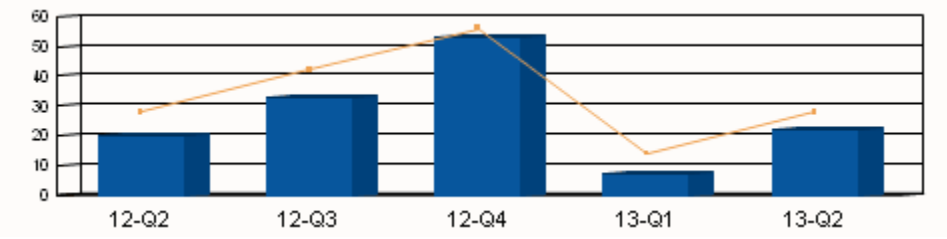
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the second quarter (Q2).

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. Target 12/13: 200 Trials.

Indicator: New Clinical Trials



	Actual	Target
12-Q2	20	**28**
12-Q3	33	**42**
12-Q4	53	**56**
13-Q1	7	**14**
13-Q2	22	**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 target by the end of the second quarter (Q2). As per our Agreement Affiliation with Queen's University, clinical trial contracts, agreements and grants are administered by the Office of Research Services' Contracts Office.

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

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

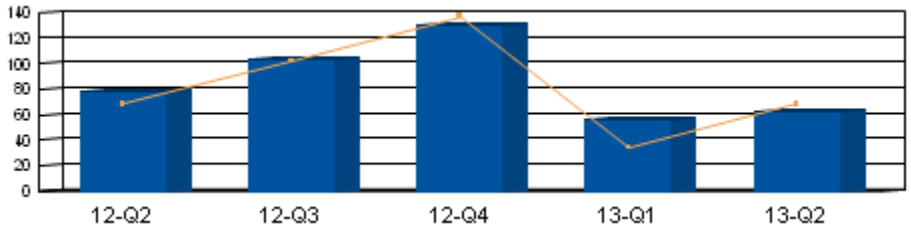
Target: Baseline 08/09: 53 Trials, Target 09/10: 56 Trials (5% increase), Target 10/11: 56 Trials. Target 11/12: 56 Trials. Target 12/13: 56 Trials.

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
12-Q2	79	**68**
12-Q3	103	**102**
12-Q4	131	**137**
13-Q1	56	**34**
13-Q2	63	**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. Target 12/13: 137 Trials.

Strategy milestone # 14

Clinical Services Roadmap initiatives launched

Strategic Direction	KGH 2015 outcome	Status
Increase our focus on complex-acute and specialty care	**KGH services are well aligned and integrated with the broader health care system**	**Green**

Indicator
KGH Participation in a Clinical Services Road Map

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   The indicator/milestone is green.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Wave One tactics are being initiated throughout the SE LHIN partner hospitals. Programs and leadership in KGH is supporting initiation within KGH and supporting the CSR Leadership group.

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

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

   New engagement with the LHIN and regional partners focusing on capacity and roles in addition to patient flow discussions.

MS #14

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Increase our focus on complex-acute and specialty care	Clinical Services Roadmap initiatives launched	KGH Participation in Clinical Services Roadmap Initiatives	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

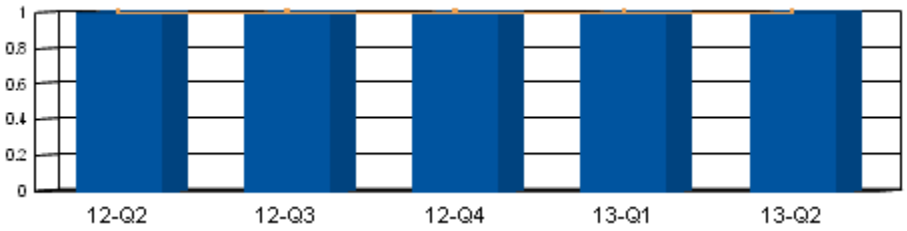
Kingston General Hospital

MS #14

Increase our focus on complex-acute and specialty care

Clinical Services Roadmap initiatives launched

Indicator: KGH Participation in Clinical Services Roadmap Initiatives



	Actual	Target
12-Q2	1	**1**
12-Q3	1	**1**
12-Q4	1	**1**
13-Q1	1	**1**
13-Q2	1	**1**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

Wave 1 initiatives have been identified and leadership from each of the partner hospitals is being sought. KGH continues to participate and provide leadership.

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. Target 12/13: Yes (Interim Targets - Q1 - Review of Surgical Charter. Q2 - Final Draft Surgical Charter for PMO Group with Working Team. Q3 - SECHEF Review of Final Draft. Q4. SECHEF Approval of Surgical Charter)

Strategy milestone # 15

Target service volumes are met

Strategic Direction	KGH 2015 outcome	Status
Increase our focus on complex-acute and specialty care	**KGH services are well aligned and integrated with the broader health care system**	**Green**
Indicator		
Percent of Contracted Volumes Achieved		

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   All target service volumes (n = 17) are met except Chronic Kidney Disease Program (weighted units) which is yellow but trending towards green.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Program leadership in SPA, Medicine and Diagnostic Imaging frequent review and reporting of volumes with programs and followed via the Waitlist Strategy Committee.

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

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

   Monthly reporting and review of all volumes (and wait times) at the Wait Times Strategy Committee.

Kingston General Hospital

MS #15

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Increase our focus on complex-acute and specialty care	Target service volumes are met	Percent of Contracted Volumes Achieved	Y	G	G	G	G	↓
		Total Inpatient Admissions	G	G	G	G	G	↑
		Total Inpatient Weighted Cases	G	G	G	G	G	↑
		OR Cases (Inpatient and Outpatient)	G	G	G	G	G	↑
		OR Hours (Inpatient & Outpatient)	G	G	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	Y	G	G	Y	↓
		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		MRI Hours (Wait Time Strategy Allocation)	Y	G	G	G	G	↑
		Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
		Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	↑
		Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	↑

	12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Primary Hip & Knee Replacement Volume (Quality Based Procedure (QBP))	N/A	N/A	N/A	Y	G	
Kidney Transplants	R	R	G	G	G	↑
Stem Cell Transplants	G	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

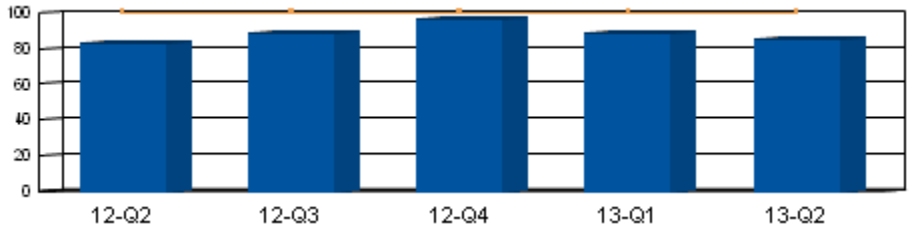
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Percent of Contracted Volumes Achieved



	Actual	Target
12-Q2	83	**100**
12-Q3	88	**100**
12-Q4	96	**100**
13-Q1	89	**100**
13-Q2	85	**100**

Interpretation - Patient And Business:

As of Q2, 23 of 27 contracted volumes were on target. The 4 that were not are wait time contracted volumes in surgery and have been highlighted under the wait time contracted volume indicator.

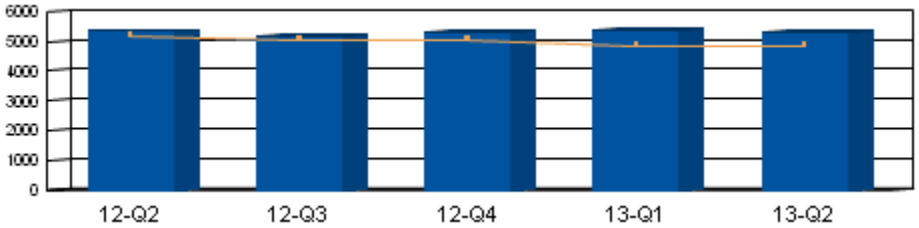
Actions & Monitoring Underway to Improve Performance:

Volumes to target are routinely monitored by appropriate committees of administration and MAC.

Definition: Service Volumes include: Stem Cell Transplants, Ambulatory Care Volumes, Cardiac (Angiography, Angioplasty, Bypass) Volumes, Chronic Kidney Disease Program-Weighted Units, CT Hours, Emergency Department Admitted Patient Volumes - All Levels of Acuity, Emergency Department Non-Admitted Low Acuity (CTAS 4&5) Volumes, Emergency Department Non-Admitted Patient Visits - High Acuity, Primary Hip and Knee Volumes,Kidney Transplants, MRI Hours, OR Cases(Inpatient and Outpatient),OR Hours (Inpatient & Outpatient), Total Inpatient Admissions, Total Inpatient Weighted Cases, Anorectal Surgery , Gall Bladder Surgery Intestinal Surgery, Groin Hernia, Ventral Hernia Surgery, Paediatric Dental Surgery , Paediatric Cleft Lip Surgery, Paediatric Scoliosis Surgery, Paediatric ACL Repair Surgery , Cancer Surgery Agreement Volumes.

Target: 2012/2013 Target: 100%

Indicator: Total Inpatient Admissions



	Actual	Target
12-Q2	5,345	**5195**
12-Q3	5,204	**5055**
12-Q4	5,332	**5058**
13-Q1	5,383	**4850**
13-Q2	5,284	**4850**

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, Target 12/13: 20,500

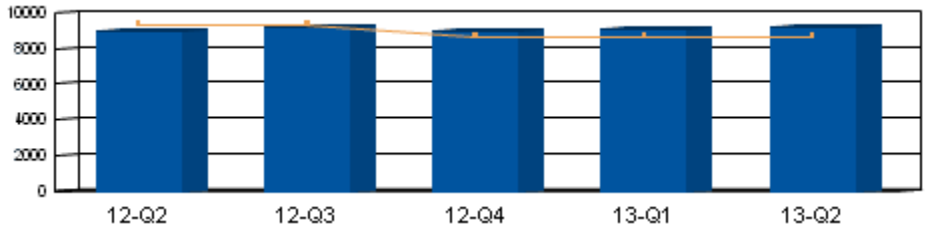
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Total Inpatient Weighted Cases



	Actual	Target
12-Q2	9,014	**9326**
12-Q3	9,207	**9326**
12-Q4	8,959	**8654**
13-Q1	9,060	**8654**
13-Q2	9,172	**8654**

Interpretation - Patient And Business:

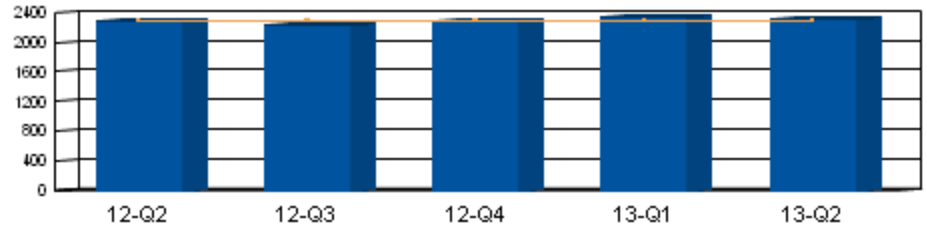
This KPI has been shaded "green" for the past 5 quarters and requires no progress comment.

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, Target 12/13: 34616

Indicator: OR Cases (Inpatient and Outpatient)



	Actual	Target
12-Q2	2,274	**2286**
12-Q3	2,234	**2286**
12-Q4	2,290	**2286**
13-Q1	2,331	**2286**
13-Q2	2,311	**2286**

Interpretation - Patient And Business:

The ability to meet case volumes for this quarter have been challenging due to influencing factors such as increased organizational patient activity and patient flow resource needs. The OR cancellation rate for this quarter doubled to 14% from Q1.

Actions & Monitoring Underway to Improve Performance:

Inpatient and outpatient OR case volume activity is monitored by OR management and the Surgical Preoperative Anesthesia (SPA). Extra operative time initiatives to address wait times has contributed to the sustained green target status.

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, Target 12/13: 9145

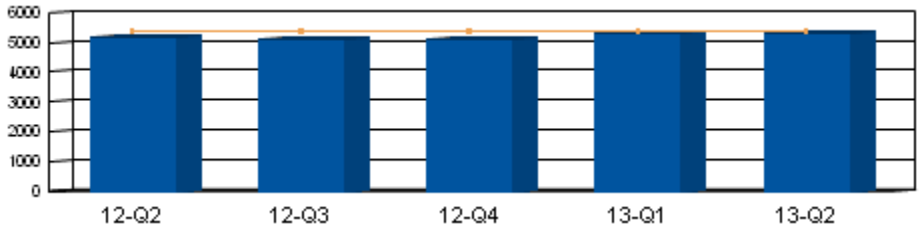
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
12-Q2	5,145	**5345**
12-Q3	5,104	**5345**
12-Q4	5,088	**5345**
13-Q1	5,294	**5345**
13-Q2	5,332	**5345**

Interpretation - Patient And Business:

This indicator has been able to stay within a" green status" even though increased patient activity and patient flow needs for the organization have influenced OR cancellations that were doubled and measured at 14% for this quarter.

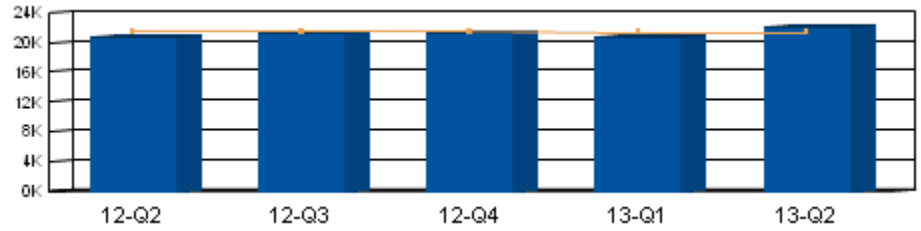
Actions & Monitoring Underway to Improve Performance:

Program leadership continues to monitor patient flow and utilize any additional strategies such as temporary Recovery Room overnight stays to ensure that OR cancellations are minimized.

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, Target 12/13: 21378

Indicator: Ambulatory Care Volumes



	Actual	Target
12-Q2	20,797	**21400**
12-Q3	21,184	**21400**
12-Q4	21,194	**21400**
13-Q1	20,796	**21323**
13-Q2	22,085	**21323**

Interpretation - Patient And Business:

Ambulatory target volumes will be reflective of the current transition of clinics/patient activity transferring to the Hotel Dieu starting in January 2013

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, Target 12/13: 85292

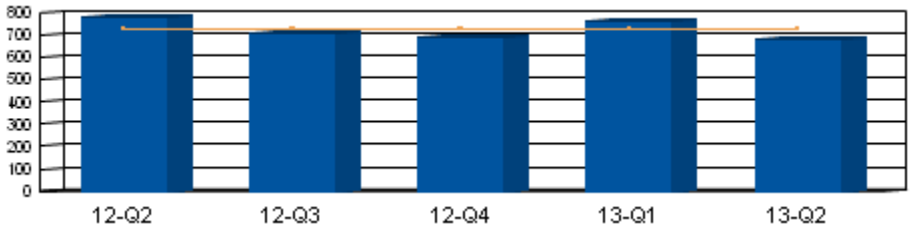
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Angiography Volumes



	Actual	Target
12-Q2	777	**725**
12-Q3	705	**725**
12-Q4	686	**725**
13-Q1	759	**725**
13-Q2	677	**725**

Interpretation - Patient And Business:

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

Business Perspective: We are on track to meet the target for this year. Funding will be earned to support completed cases and KGH will have achieved the volumes that address demand in the community.

Actions & Monitoring Underway to Improve Performance:

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

Please note that volumes are based on last year's funded volumes as funded volumes for 2013 have not been received yet.

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: 2900, Target 12/13: 2900

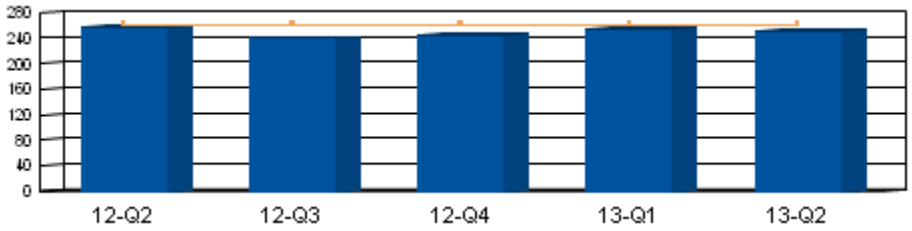
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
12-Q2	256	**262**
12-Q3	240	**262**
12-Q4	245	**262**
13-Q1	254	**262**
13-Q2	252	**262**

Interpretation - Patient And Business:

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

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

Actions & Monitoring Underway to Improve Performance:

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

We still do not know what our funded volumes are for F13 and are assuming the same targets as last fiscal until we hear otherwise. Receiving funded volume targets so late into the fiscal year makes planning for any increase in activity very difficult.

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

Target: Baseline 08/09: 1084, Target 09/10: 1150, Target 10/11: 1150, Target 11/12: 1050, Target 12/13: 1050

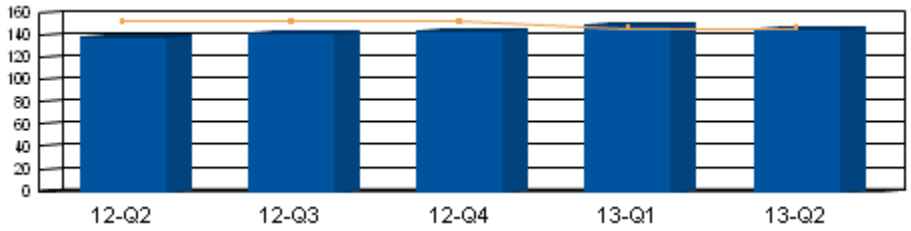
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
12-Q2	138	**152**
12-Q3	141	**152**
12-Q4	143	**152**
13-Q1	148	**146**
13-Q2	146	**146**

Interpretation - Patient And Business:

Patient Perspective: Maximum recommended wait times for all bypass surgeries are being met and patient needs are being met. Volumes have remained constant over the past 3 years.

Business Perspective: The targeted funded volumes for all cardiac surgeries are on track at the end of Q2.

Actions & Monitoring Underway to Improve Performance:

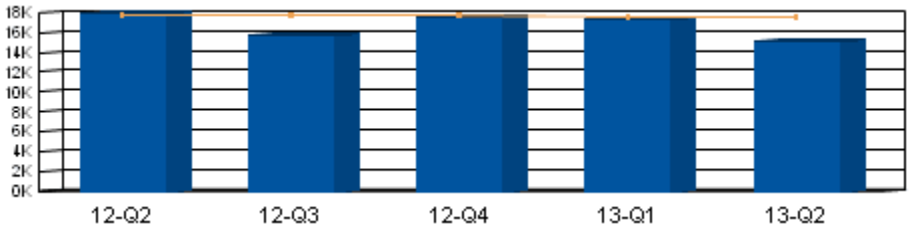
Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Program and the Wait Times Committee in order to achieve target volumes and wait times and to mitigate cancellations. Surgical volumes and wait times are monitored by the Cardiac Care Network (CCN) of Ontario. The monthly reports generated by the CCN allow us to benchmark against peer hospitals and monitor trends across the province.

Recruitment for a 4th cardiac surgeon is underway.

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, Target 12/13: 582

Indicator: Chronic Kidney Disease Program - (Weighted Units)



	Actual	Target
12-Q2	17,888	**17707**
12-Q3	15,792	**17707**
12-Q4	17,638	**17707**
13-Q1	17,336	**17498**
13-Q2	15,171	**17498**

Interpretation - Patient And Business:

Overall weighted units (WU) are within normal variable limits across the Program (medicine) and within the Renal Service. One area of concern is the qualifying clinic activity, new definitions are being implemented and a redesign of clinic services and processes within these new definitions is now underway.
The WUs cover all aspects of the care continuum, at a high level, and do not allow care elements to be highlighted.

Actions & Monitoring Underway to Improve Performance:

The tactics for the service support a redesign of clinic services, improving independent dialysis rates and improving the appropriate vascular access modes. Work is underway on all these areas, the biggest area of change will be that related to clinic services.

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: 70828, Target 12/13: 69992

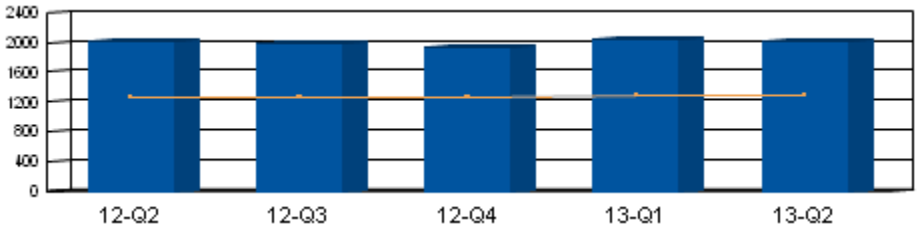
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
12-Q2	2,015	**1263**
12-Q3	1,979	**1263**
12-Q4	1,929	**1263**
13-Q1	2,032	**1286**
13-Q2	2,026	**1286**

Interpretation - Patient And Business:

We continue to run a high number of hours with the 2 CT units. This number of hours is required to meet the needs of the organization's patients and healthcare providers.

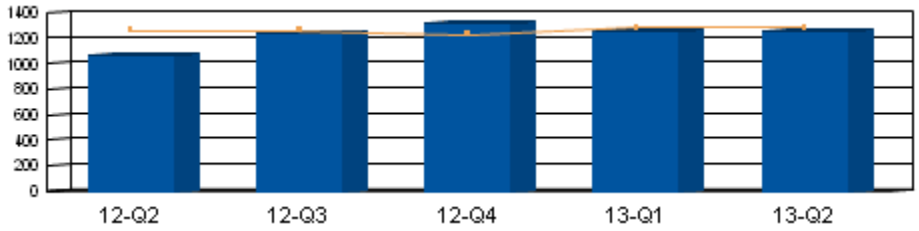
Actions & Monitoring Underway to Improve Performance:

Continue to monitor hours and budget monthly.

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, Target 12/13: 5050 hrs.

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
12-Q2	1,071	**1259**
12-Q3	1,239	**1259**
12-Q4	1,322	**1228**
13-Q1	1,262	**1283**
13-Q2	1,250	**1283**

Interpretation - Patient And Business:

Recruitment of 5th FT MRI technologist has allowed KGH to reach full operational hours. (105-109 operational hours per week.) Achieving this staffing level is instrumental to improving efficiency, meeting service demands and driving down the wait times.

Actions & Monitoring Underway to Improve Performance:

Continue to support and maximize the efficiency of a 5.5 FTE staffing model to best meet the needs of the MRI department.

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, Target 12/13: 5134 hrs.

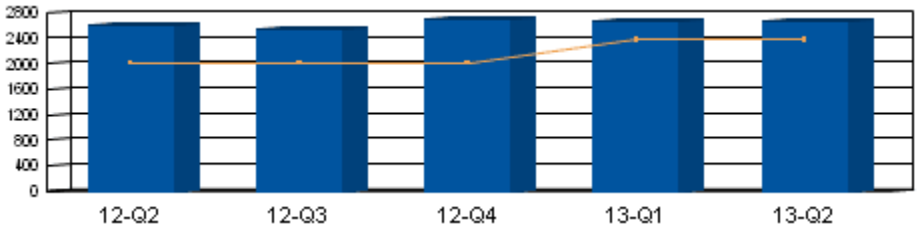
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

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



	Actual	Target
12-Q2	2,591	**2002**
12-Q3	2,555	**2002**
12-Q4	2,713	**2002**
13-Q1	2,658	**2370**
13-Q2	2,683	**2370**

Interpretation - Patient And Business:

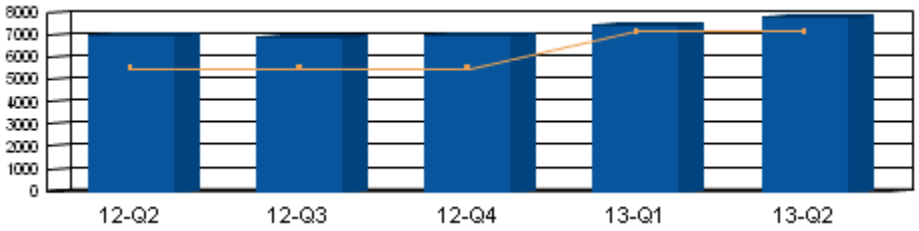
Indicator Green for Past 5 Quarters and Does Not Require Comment

Actions & Monitoring Underway to Improve Performance:

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: 8008, Target 12/13: 8163

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



	Actual	Target
12-Q2	6,953	**5481**
12-Q3	6,867	**5481**
12-Q4	7,033	**5481**
13-Q1	7,423	**7149**
13-Q2	7,766	**7149**

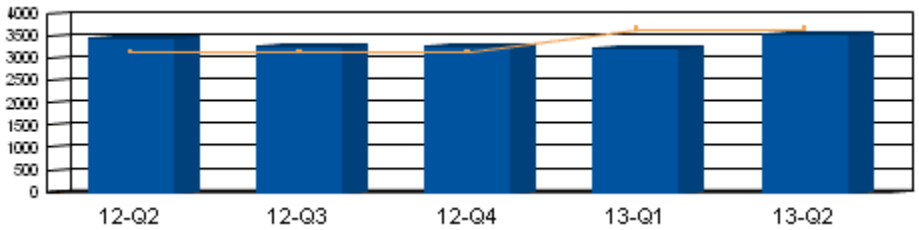
Interpretation - Patient And Business:

Indicator Green for Past 5 Quarters and Does Not Require 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: 21924, Target 12/13: 25924

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



	Actual	Target
12-Q2	3,441	**3138**
12-Q3	3,250	**3138**
12-Q4	3,284	**3138**
13-Q1	3,242	**3647**
13-Q2	3,547	**3647**

Interpretation - Patient And Business:

Indicator Green for Past 5 Quarters and Does Not Require 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: 12552, Target 12/13: 12552

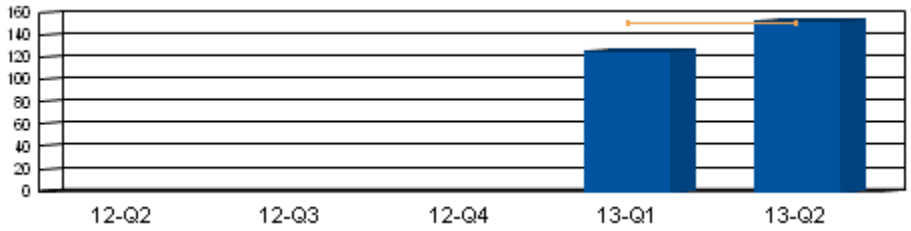
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Primary Hip & Knee Replacement Volume (Quality Based Procedure (QBP))



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	126	**150**
13-Q2	152	**150**

Interpretation - Patient And Business:

For this quarter the combined volumes are in the "green status" zone however the overall YTD volumes indicate that there is a negative variance of 6 hips and 13 knees at the end of September. Contributing to the inability to make up the difference in achieving these volumes is directly related to an OR cancellation rate for Q2 of 14% which is doubled from Q1. The increase in OR cancellations is the result of a) increased organizational patient activity (increased urgent critical care needs) and b) limited bed availability (increased LTD and ALC patients) requiring a reduction in elective patient activity.

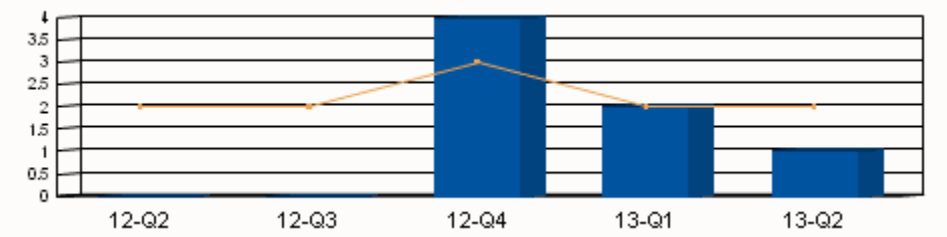
Actions & Monitoring Underway to Improve Performance:

Program management working in collaborated with the department of surgery/anesthesia has focused all efforts on minimizing cancellations by utilizing the recovery room as a temporary short stay unit to place patients until bed availability improves. There is also a protocol implemented that ensures that first cases at a minimum are completed. A revised OR schedule was created starting in September with a pilot project to ensure that all operational efficiencies are in place to ensure that sufficient time was available to complete all scheduled cases.

Definition: As of Fiscal 12/13, primary hip and knee replacement volume has been removed from the Wait Time Strategy (WTS) Allocation contract. It is now covered off under year 1 Quality Based Procedure (QBP) funding methodology. As a result, there is no longer a base and incremental component to the volume. Both procedures have now been assigned a total volume for the year as per negotiation with the SE LHIN. The KGH is obligated to deliver on 100% of the volume. Both primary hip and primary knee cases have been assigned a cost that is earned back by the hospital as the agreed volumes are achieved.

Target: Baseline 08/09: 878, Target 09/10: 876, Target 10/11: 876, Target 11/12: 819, Target 12/13: 599

Indicator: Kidney Transplants



	Actual	Target
12-Q2	0	**2**
12-Q3	0	**2**
12-Q4	4	**3**
13-Q1	2	**2**
13-Q2	1	**2**

Interpretation - Patient And Business:

Kidney Transplant activity is low volume and driven by available organs (deceased donors). Activity is therefore unpredictable in time.

Actions & Monitoring Underway to Improve Performance:

Kidney Transplantation is a significant life-changing opportunity for recipients. At the present time, organ availability drives the clinical activity, support and promotion of a 'donor-culture' is important for the organization to recognize.

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, Target 12/13: 9

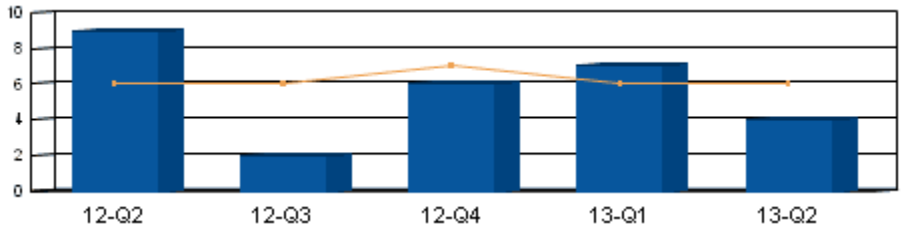
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Stem Cell Transplants



	Actual	Target
12-Q2	9	**6**
12-Q3	2	**6**
12-Q4	6	**7**
13-Q1	7	**6**
13-Q2	4	**6**

Interpretation - Patient And Business:

At the end of Q2 F13, KGH is on track for its stem cell transplant volumes

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, Target 12/13: 25

Strategy milestone # 16

Evidence-based guidelines are adopted in 12 clinical areas

Strategic Direction	KGH 2015 outcome	Status
Increase our focus on complex-acute and specialty care	**Best evidence used to guide practice**	**Green**
Indicator		
Number of Clinical Areas That Have Implemented Open Source Order Sets (OSOS)		

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Green performance on this indicator with involvement of many programs (SPA, Medicine) and services (Infection Prevention and Control).

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   A focus on quality and safety has been the major driver for up take by the programs.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Acquisition and implementation of Entry Point, an electronic repository of Order Sets, will be a major initiative for ensure the viability of the Order Set project.

Kingston General Hospital

MS #16

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Increase our focus on complex-acute and specialty care	Evidence-based guidelines are adopted in 12 clinical areas	Number of Clinical Areas that have Implemented Open Source (OS)	R	G	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

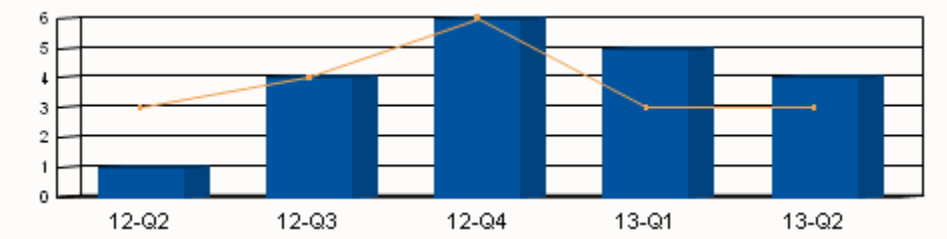
Kingston General Hospital

MS #16

Increase our focus on complex-acute and specialty care

Evidence-based guidelines are adopted in 12 clinical areas

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



	Actual	Target
12-Q2	1	**3**
12-Q3	4	**4**
12-Q4	6	**6**
13-Q1	5	**3**
13-Q2	9	**6**

Interpretation - Patient And Business:

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

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, Target 12/13: 12

Strategy milestone # 17

Overall staff satisfaction rating improve by 20%

Enabler	KGH 2015 outcome	Status
People	**KGH is designated as one of the best places to work**	**Red**
Indicator(s)		
Staff Satisfaction Ratings Will Improve by 20% based on Responses of Agree and Strongly Agree to the Statement "I am Satisfied with this Organization"		

1. **What is our actual performance on each of the indicators for this milestone as listed above?** Communication of Workplace Pulse survey results to the KGH Community occurred. Average 12 month sick day has dropped and finished Q2 at 10.85. Overtime continues to be a challenge, in particular in the Critical Care Area even though staff completed orientation in August. A project manager has been hired for the Scheduling project, and that is trending green.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
Refreshed awareness of Attendance Promotion and hospital's target. Vacancies and retention continue to impact overtime in Critical Care. Increased activities than planned impacted overtime in Medicine, Critical Care and Neonatal Critical Care.

3. **Are we on track to meet the milestone by year end?**
This is a stretch target, and we will be unable to assess until the survey in February 2013; however we are trending to reach the associated targets except for overtime.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
Action plan is underdevelopment for the Workplace Pulse Survey and preparation is commencing for the re-survey in February 2013. New Director hired, and Recruitment redesign and RFP for applicant tracking system to improve the time to hire, and tactics to improve retention. A new critical care recruitment plan is being developed and stay interviews implemented . Wellness Centre re-establishment is being explored as well as a draft program for Wellness was reviewed with the CEO – no funding has been allocated at this time. Employee kiosk project to enable access to KGH Today, Email and Postings was initiated.

Kingston General Hospital

MS #17

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
People	Overall staff satisfaction ratings improve by 20%	Staff Satisfaction Ratings Will Improve By 20% based on Responses of Agree and Strongly Agree to the Question "Overall I am Satisfied With This Organization"	N/A	N/A	R	N/A	N/A	
		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
		Launch the Staff Scheduling Project	R	N/A	G	N/A	G	↑
		Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
		Percent Sick Time Hours	Y	Y	Y	Y	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

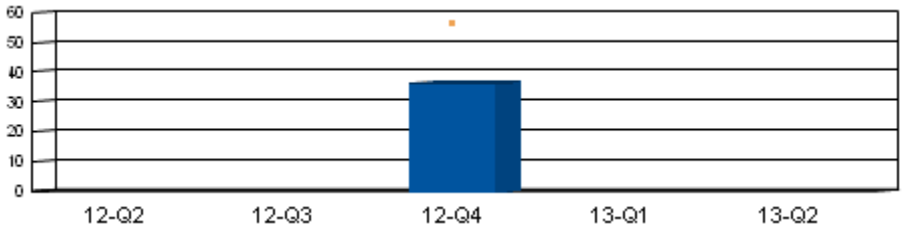
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Staff Satisfaction Ratings Will Improve By 20% based on Responses of Agree and Strongly Agree to the Question "Overall I am Satisfied With This Organization"



	Actual	Target
12-Q2		
12-Q3		
12-Q4	36	**56**
13-Q1		
13-Q2		

Interpretation - Patient And Business:

This indicator is scheduled for Q4. Initial work plan is beginning in Q3 and Q4 to run focus groups and discuss qualitative and quantitative data from Worklife Pulse and Patient Safety surveys to which will result in recommendations for action. In addition to the wellness initiative, we are launching 1, 3 and 6 month stay interviews with new nursing hires. Information will be shared with managers along with any information from exit interviews we can obtain.

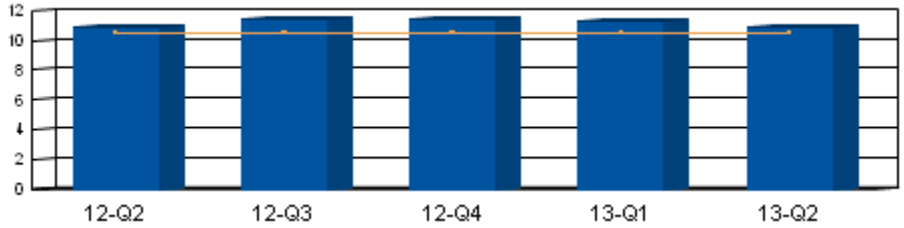
Actions & Monitoring Underway to Improve Performance:

Workplan for Worklife Pulse and Patient Safety surveys and action planning now taking place.

Definition: The Pulse Survey conducted in March of each year currently has a 36% positive response rate to the comment "overall I am satisfied with this organization". Through the development of various initiatives at all levels of the organization it is anticipated that the hospital will realize a score in the area of 56% to this comment in March 2013.

Target: • Q1 – Survey results received and incorporated into the Mock Accreditation processes (Green) Q2 - Survey results communicated formally in the organization (Green) Q3 - Input obtained from key stakeholder group and Executive Management Committee approved Action Plan Q4 - Survey and comunication plan approved and survey conducted end of February

Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
12-Q2	10.9	**10.5**
12-Q3	11.4	**10.5**
12-Q4	11.4	**10.5**
13-Q1	11.3	**10.5**
13-Q2	10.9	**10.5**

Interpretation - Patient And Business:

The overall corporate rolling twelve month average at the end of September was 10.85 and trending downward throughout the quarter. The number of incidences on average remained stable throughout the quarter and at some of our lowest levels. The monthly averages in the fiscal year are on target to date and showing better than one year ago.

Actions & Monitoring Underway to Improve Performance:

Other programs are being reviewed and the sick time poster to determine if changes may be required to maintain best practices. The recent focus on part time staff in the attendance program while not a driver for the average number, assists in staffing, consistency and drives perceptions of fairness. The focus on flu shots and wellness activities will assist in driving prevention of absences over the remainder of the fiscal year.

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, Target 12/13: 10.5

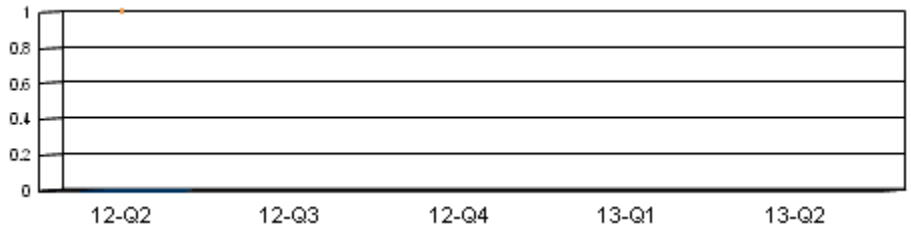
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Launch the Staff Scheduling Project



	Actual	Target
12-Q2		**1**
12-Q3		
12-Q4		
13-Q1		
13-Q2		

Interpretation - Patient And Business:

Project Manager is hired and onboard; Project Director hired and Executive Sponsor assigned: ER; Project team is established and meeting regularly; work breakdown is proceeding to determine workloads, and ensuing project plan. Resourcing plan is being addressed; Scope now includes master schedules; Communications has been taken out of change team responsibility and is now the responsibility of the Project Manager to lead.

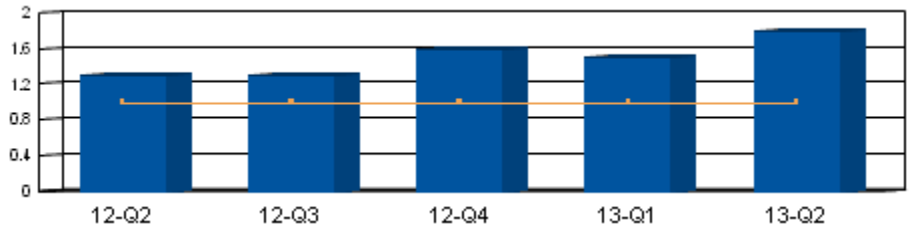
Actions & Monitoring Underway to Improve Performance:

Project launch date to be determined.

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, Target 12/13: Yes (Interim Targets - Q1 - Project Management In Place & Project Charter Developed. Q2 - Project Plan Finalized & Resources Secured. Q3 - Review & Standardize Where Applicable in Pt Care Areas. Q4 - Corporate Scheduling Office Established)

Indicator: Percent of Overtime Hours



	Actual	Target
12-Q2	1.3	**1.0**
12-Q3	1.3	**1.0**
12-Q4	1.6	**1.0**
13-Q1	1.5	**1.0**
13-Q2	1.8	**1.0**

Interpretation - Patient And Business:

Overtime was a challenge over the summer months and was elevated in many areas. Negative variances for both overtime hours and dollars existed throughout the quarter with NICU, Critical Care and Medicine programs showing the highest numbers.

Actions & Monitoring Underway to Improve Performance:

Staffing levels, occupancy levels and activity influenced overtime more than levels of staff absences. Levels of staff and training continued to impact throughout the quarter with some improvements which will assist with overtime reduction in remainder of the fiscal year.

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%, Target 12/13 0.99%

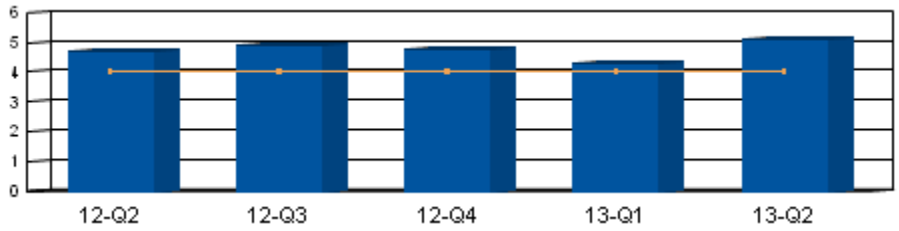
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Percent Sick Time Hours



	Actual	Target
12-Q2	4.7	**4**
12-Q3	4.9	**4**
12-Q4	4.8	**4**
13-Q1	4.3	**4**
13-Q2	5.1	**4**

Interpretation - Patient And Business:

Although year to date sick time hours are in a negative variance, the total dollars were in a solid position for the quarter posting positive variances. The highest variances were in the Critical Care, Emergency and Surgical programs.

Actions & Monitoring Underway to Improve Performance:

Resolution of staffing issues and workload issues will have a positive impact on sick hours.

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%, Target 12/13 4.0%

Strategy milestone # 18

Health and Safety Scorecard targets are met

Enabler	KGH 2015 outcome	Status
People	**All preventable harm to staff is eliminated**	**Yellow**

Indicator(s)
Number of Health & Safety Scorecard Target Indicators are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Fourteen (14) of the indicators are within the target range; the goal being seventeen (17) out of twenty-one (21) being in the range. NEER statement continues to demonstrate good performance and rebate will be received this fall.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Summer vacancies impacted management ability to respond within 21 days to JHSC workplace inspections which resulted in a 59% compliance. Significant increase in needle stick injuries with a total of 22. Average in past year has been 7-12. The butterfly collection sets contributed to 36% and improper activation of safety mechanism on needles contributed to 50% of injuries. Health care claims increased with 27; majority were related to MSIs (12) and 22% were in Environmental Services. Seventeen (17) MSIs were reported and one (1) resulted in a lost time injury; 57% were during patient handling activities.

3. **Are we on track to meet the milestone by year end?**
   As Q1 hit the target, we could recoup during Q3 and be on track for year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Review process for next summer's follow-up on JHSC inspections to account for vacations. Butterfly collection set has been converted to a safer Push Button Butterfly in October; new Nexiva IV catheter being trailed October. Needlestick injury online training under development. Exploring why central lines are not safety engineered. MSI prevention program currently being evaluated by Ergonomist.

Kingston General Hospital

MS #18

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
People	Health and Safety Scorecard targets are met	Number of Health & Safety Scorecard Target Indicators Met	N/A	N/A	N/A	G	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

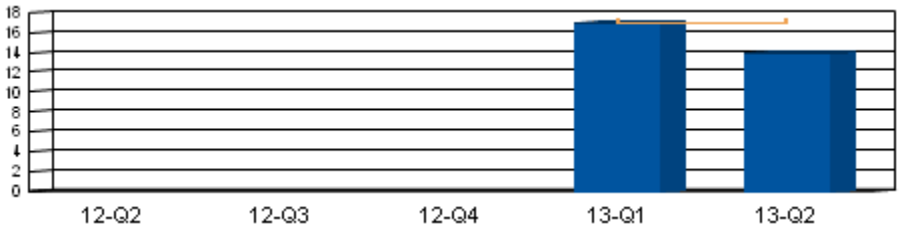
Kingston General Hospital

MS #18

People

Health and Safety Scorecard targets are met

Indicator: Number of Health & Safety Scorecard Target Indicators Met



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	17	**17**
13-Q2	14	**17**

Interpretation - Patient And Business:

In addition to the 4 measures that were red in Q1 (completion of incident investigations, management response to JHSC inspections/recommendations, completion of quarterly management inspections, and respirator fit testing compliance), the following 3 additional performance measures are outside of target for Q2: incidence of needlestick injuries, incidence of WSIB healthcare claims, and incidence of musculoskeletal injuries (MSIs).

Actions & Monitoring Underway to Improve Performance:

See OHS scorecard for more information.

Definition: Occupational Health & Safety indicators demonstrate the hospital's progress in eliminating all preventable harm to staff. Through the measurement of leading health & safety indicators, we demonstrate our compliance with policy and legislation aimed at creating a safe work environment for staff. Lagging indicators are the injury/illness outcomes that help us to assess and improve our Health and Safety Management System.

Target: 12/13 Target: 17 of 21

Strategy milestone # 19

Employee engagement action plans are in place at all team levels

Enabler	KGH 2015 outcome	Status
People	**Staff are engaged in all aspects of our quality, safety and service improvement initiatives**	**Red**

Indicator(s)
Employee Action Plans at Corporate and Team Level are Complete

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   This has not been commenced formally.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The Executive Management Committee made the decision not to conduct a formal engagement survey this year, but rather commence leadership engagement training and action planning around the Workplace Pulse Survey from March 2012 which will occur again February 2013. It was also identified that a physician engagement survey was required this year, in order to be compliant with the Excellent Care for All Act; however, no money has been allocated to the initiative.

3. **Are we on track to meet the milestone by year end?**
   We are not on track to meet the milestone by year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Presentation made to the Executive Management Committee regarding the planned engagement activities for Fiscal 2013. Meetings scheduled to discuss physician surveys and 360 survey activity. An expert in engagement activities has been hired for a 6 month term. Request for funding has been made. Debriefs are underway regarding Workpulse Survey and dependent on funding available; managers may be requested to create an action plan in December/January based upon March 2012 surveys.

Kingston General Hospital

MS #19

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
People	Employee engagement action plans are in place at all team levels	Employee Engagement Action Plans at Corporate and Team Level are Complete	N/A	N/A	N/A	N/A	R
		Percent of Staff that Complete Mandatory Online Training Programs	Y	Y	Y	Y	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

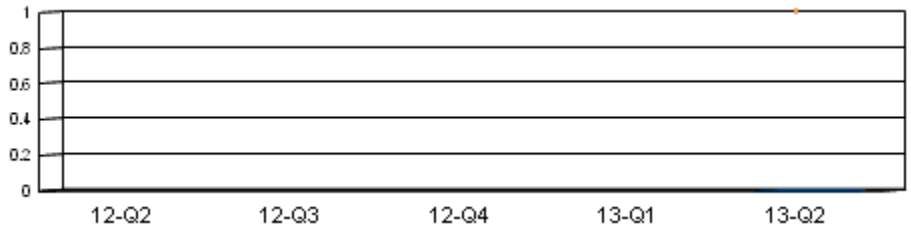
Kingston General Hospital

MS #19

People

Employee engagement action plans are in place at all team levels

Indicator: Employee Engagement Action Plans at Corporate and Team Level are Complete



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	N/A	**N/A**
13-Q2	0	**1**

Interpretation - Patient And Business:

Activity has not commenced. Action is underway to begin focus groups to build engagement action plans around Worklife Pulse survey and Patient Safety survey results.

Actions & Monitoring Underway to Improve Performance:

Beginning focus groups during the month of November

Definition: On completion of the formal Staff Engagement Survey (scheduled for October 2012) responses will be analyzed to identify key opportunities for improvement at the departmental or program level. As a result leaders will be expected to develop plans that identify the improvement opportunities and what they will be doing to facilitate improvement.

Target: Q1 - N/A Q2 - Engagement Strategy completed , approved by Executive Management Committee and budget assigned Q3 - Selection of survey modality/vendor and implementation plan finalized to launch "leading for engagement" Q4 –Training and action planning by teams

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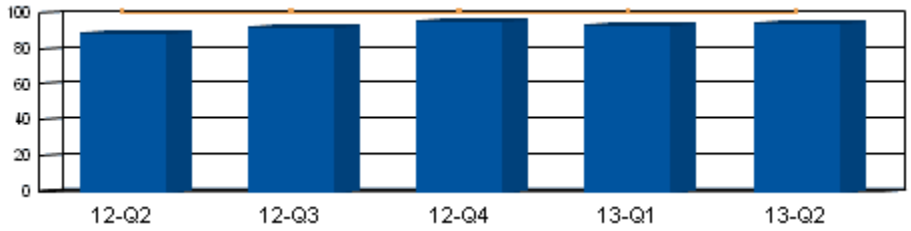
Indicator: Percent of Staff that Complete Mandatory Online Training Programs



	Actual	Target
12-Q2	88	**100**
12-Q3	92	**100**
12-Q4	95	**100**
13-Q1	93	**100**
13-Q2	94	**100**

Interpretation - Patient And Business:

93.8 of staff have completed mandatory training programs, an increase from last quarter of 92.4%.

Actions & Monitoring Underway to Improve Performance:

Increase due to increased communication from PSOE Leadership and Learning Department. Will continue to send out monthly reminders to all staff - with specific staffcompletion rates for Directors to communicate with departments.

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 l 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%, Target 12/13: 100%

Strategy milestone # 20

100% of our KGH managers complete continuous improvement training

Enabler	KGH 2015 outcome	Status
Processes	**Continuous improvement environment created with consistent use of LEAN principles**	**Green**

Indicator(s)
Percent of Management Staff that Complete Mandatory Process Improvement Training

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Targeted for this quarter was for 24 additional leaders to complete training and 36 leaders completed 4 follow-up sessions. These targets were achieved or partially achieved with 63 (70%) out of 90 managers trained and 29 out of 90 completed one improvement cycle using PSDA and participated in VSM exercise.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Numerous workshops scheduled, follow-up on the scheduling of the 4 one-on-one sessions.

3. **Are we on track to meet the milestone by year end?**
   Yes, we will meet this milestone by year end.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Continued follow-up to schedule managers, and ensure completion of his/her improvement activity.

Kingston General Hospital

MS #20

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
Processes	100% of KGH managers complete continuous improvement training	Percent of Management Staff Completing Mandatory Process Improvement Training	R	R	R	G	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

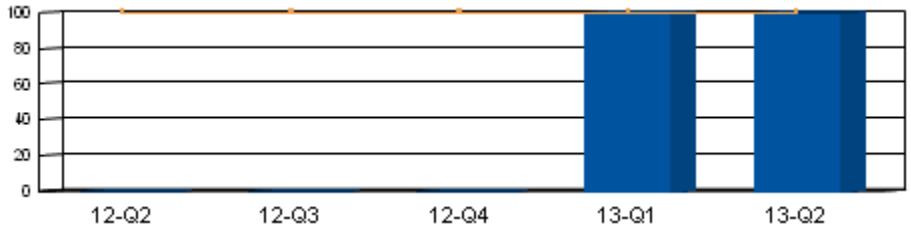
Kingston General Hospital

MS #20

Processes

100% of KGH managers complete continuous improvement training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
12-Q2		**100**
12-Q3		**100**
12-Q4		**100**
13-Q1	100	**100**
13-Q2	100	**100**

Interpretation - Patient And Business:

Participation in training has been excellent and all leaders are registered for training. There is an opportunity for leaders to complete the requirements of the training which are to complete one improvement cycle using PDSA and participate in a Value Stream Mapping exercise. We anticipate that over the next quarter much of this work will be done.

Actions & Monitoring Underway to Improve Performance:

Note that the target set for Q2 was to train 24 leaders. As the end of Q2, we had gone well beyond training the core leadership group to include managers, charge nurses, project team members, etc. totally an addition 63 staff. Training will continue throughout the remainder of the fiscal year.

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: 11/12 Target: 100% 12/13 Q1 Target: Intro and Development, 12/13 Q2 Additional 24 leaders CI; 36 leaders complete four follow-up, 12/13 Q3 Additional 24 leaders CI; 24 leaders complete four follow-up, 12/13 Q4 Additional 24 leaders CIT 30 leaders complete four follow-up.

Strategy milestone # 21

Phase 2 redevelopment functional programming commences

Enabler	KGH 2015 outcome	Status
Facilities	**Phase 1 redevelopment is complete, Phase 2 construction is underway and KGH has sufficient parking**	**Green**

Indicator
Phase 2 Redevelopment Project Targets are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The Stage 1 Proposal Submission is complete, with the exception of: the financing and fundraising plan which is expected to be completed in Q3. The Stage 1 Proposal is currently progressing through the various stages of internal approval. Our goal is to be ready to submit the Proposal to the LHIN and MOHLTC in December 2012.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** We have had support from across the hospital to complete the required supporting documents for Stage 1; the most significant documents being the Master Plan and Master Program. This process was led by Krista Wells-Pearce, Director Joint Planning Office (JPO). We also engaged the services of Agnew Peckham and HDR Architects to support the development of these documents.

   In Q2 the SELHIN facilitated a meeting of regional hospitals, which helped us meet the required support and input of hospitals in the region for the Stage 1 submission.

3. **Are we on track to meet the milestone by year end?**
   The fundraising and financing plan is in progress and meetings are underway with our partners (University Hospitals Kingston Foundation, PCC, and HDH) to draft a local share plan. We are also still in process of finalizing the support of Queens University for the inclusion of the Etherington Building in our plans. Meetings have gone well in Q2 with Queens to develop a plan for presentation to the Queen's Board in December.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Meetings to complete the Financing and Fundraising Plan are set for November with our partners. Similarly work with Queens is progressing with the assistance of Richard Rezneck, Dean of Health Sciences. At this time we remain optimistic that both these components will be advanced in November.

MS #21

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2
Facilities	Phase 2 redevelopment functional programming commences	Phase 2 Redevelopment Project Targets are Met	N/A	N/A	N/A	G	G

Indicates improving performance to target over the past 5 quarters

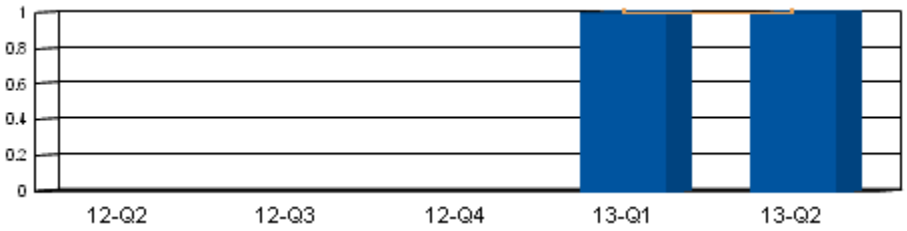
Indicates worsening performance to target over the past 5 quarters

MS #21

Facilities

Phase 2 redevelopment functional programming commences

Indicator: Phase 2 Redevelopment Project Targets are Met



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1	1	**1**
13-Q2	1	**1**

Interpretation - Patient And Business:

The Stage One Proposal Submission is complete and is currently progressing through the various stages of internal approval. Our target submission date to the LHIN and MOHLTC is December 2012.

Actions & Monitoring Underway to Improve Performance:

Following submission of the Stage One Proposal to the LHIN and MOHLTC we will await approval to proceed to Stage Two: Functional Program. In preparation for this next phase, meetings will begin with each program/department involved to discuss research requirements, site visit options, etc. so that programming discussions will be better informed when the process begins.

Definition: The Phase 2 Redevelopment Project plans are being prepared in compliance with MOHLTC Capital Planning Toolkit. The Stage One: Proposal submission will be submitted to the MOHLTC in Fall 2012. Upon MOHLTC approval of the Stage One Proposal, the Stage Two: Functional Program process will commence. The planning schedule shows that Functional Programming will commence in Q4.

Target: 12/13 Q1 Target: Complete State 1 Submission. 12/13 Q2 Target: Steering Committee Completes & Approves Master Program/Plan & Creates Financial Plan. 12/13 Q3 Target: Submit Financial Plan to MOH. 12/13 Q4 Target: MOH Approval to go to Stage 2.

Strategy milestone # 22

Carpets are removed from 75% of patient areas

Enabler	KGH 2015 outcome	Status
Facilities	**KGH is clean, green and carpet-free**	**Green**

Indicator
Quarterly Carpet Removal Targets are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** We are now 48 percent complete (plan was 52%). We are slightly below target because we still have not completed the carpet removal in Kidd 1 and Kidd 2 corridors.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The corridor removal work was not completed in Q2, because of the decision to operate a double shift to expedite the carpet removal in the Cardiac Sciences Unit, and limit the clinical disruption that relocation would have caused.

3. **Are we on track to meet the milestone by year end?**.
The double shift however has accelerated the phasing sequence for the inpatient units, and as such the overall timeline for removal of carpet on the inpatient units has not been affected. We expect to be back on schedule by the end of the year.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Q3 will see the completion of Kidd 4 and progress on removals in the Kidd 1 and Kidd 2 corridors. Next year will see Kidd 3, Kidd 5 and Davies 5 being completed and these will be the last of the inpatient units, which will be followed by FAPC 5,4,3, and 1 (Ambulatory areas).

MS #22

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Facilities	Carpets are removed from 75% of patient areas	Quarterly Carpet Removal Targets are Met	G	G	G	Y	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

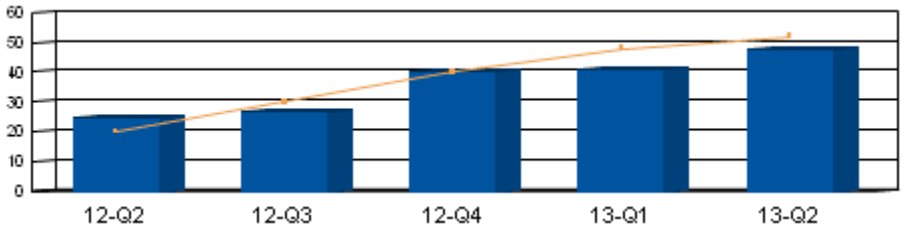
Kingston General Hospital

MS #22

Facilities

Carpets are removed from 75% of patient areas

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
12-Q2	25	**20**
12-Q3	27	**30**
12-Q4	40	**40**
13-Q1	41	**48**
13-Q2	48	**52**

Interpretation - Patient And Business:

We are slightly below target for this quarter. In Q1 we reported that we were behind because we had not yet completed carpet removal in Kidd 1 and Kidd 2 corridors due to logistical conflicts with other project work. This corridor removal work was not completed in Q2 because of the decision to operate a double shift to expedite the carpet removal in the Cardiac Sciences Unit, and limit the clinical disruption that their relocation caused. This shift accelerated the overall phasing sequence for the inpatient units, and as such the timeline for removal on the inpatient units has not been affected by the lag in achieving the planned 52% removal for this quarter.

Actions & Monitoring Underway to Improve Performance:

Q3 will see the completion of Kidd 4 and progress on removals in the Kidd 1 and Kidd 2 corridors. Kidd 3, Kidd 5 and Davies 5 will be the last of the inpatient units to be completed, followed by FAPC 5,4,3, and 1.

Definition: Phase 1B of the Carpet Removal Plan will be completed and Phase 2 will begin this year. Removal targets, based on % of square footage removed in patient care areas, are as follows: Q1 48%, Q2 52%, Q3 64%, Q4 75%.

Target: 12/13 Target: 75% (Interim Targets - Q1 - 48%, Q2 - 52%, Q3 - 64, Q4 - 75%)

Strategy milestone # 23

Discharge summaries are sent to primary care providers within 72 hours of patient discharge

Enabler	KGH 2015 outcome	Status
Technology	**Rapid transmission of information improves care and operational efficiency**	**Red**

Indicator
Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The result at Q2 is 37% completion before 72 hours (compared to our target of 80%). We have seen slight drop in compliance from the prior quarter. The issue is that summaries are not finalized until the attending physician signs off the discharge summary, and at present there is no automated notification of the attending of a summary awaiting sign off.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Ongoing efforts to improve the electronic notification of physicians through our Patient Care System (Quadramed) have to date been unsuccessful. This has been the largest barrier to physicians being notified in a timely manner as to the need to sign off the discharge summaries.

3. **Are we on track to meet the milestone by year end?** At this time, achievement of the milestone continues to be a real risk.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Physician compliance continues to be monitored and reported and efforts continue to create notifications through the PCS system. Alternative means to achieve the notification are being explored by Information Management and Medical Affairs, including exploration of introducing new standard screens and information for physicians at sign on to the PCS. An update on these efforts will be provided with Q3 reports.

Kingston General Hospital

MS #23

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Technology	Discharge summaries are sent to primary care providers within 72 hours	Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	R	N/A	G	G	G	↑
		Implementation of an Order Management System for Labs on All Inpatient Areas (% Completion).	R	R	G	G	G	↑
		Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *	R	R	R	R	R	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

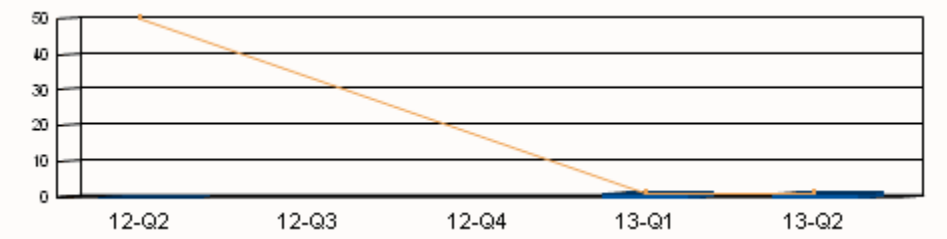
Kingston General Hospital

MS #23

Technology

Discharge summaries are sent to primary care providers within 72 hours

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



	Actual	Target
12-Q2		**50**
12-Q3		
12-Q4		
13-Q1	1	**1**
13-Q2	1	**1**

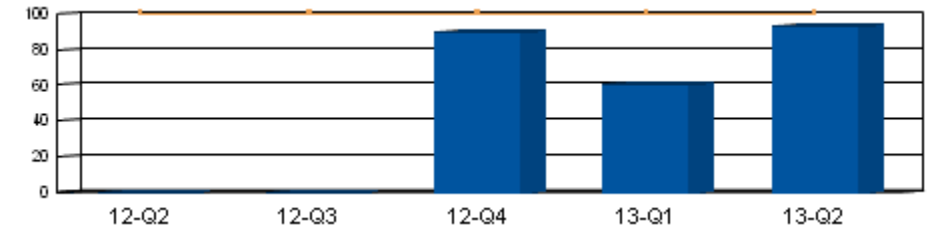
Interpretation - Patient And Business:

Project Charter approved; Project manager appointed; Several working groups formed; No cabinets in place yet

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%. Updated Target 12/13: 25% (Interim Targets: Q1- Negotiate Contract. Q2 - Finalize Implementation Plans. Q3 - Complete 12.5. Q4 - 25)

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



	Actual	Target
12-Q2		**100**
12-Q3		**100**
12-Q4	90	**100**
13-Q1	60	**100**
13-Q2	93	**100**

Interpretation - Patient And Business:

Phase 1 LOE for inpatient units = 100% (100% of units have gone live, 93% compliance ie. sending tests requests from unit vs. paper requisitions).

Phase 2 renal program is at 71% completion

Actions & Monitoring Underway to Improve Performance:

A small tiger task team has been created to identify the issues around why we have not achieved 100% compliance for inpatient test ordering.

The findings will be presented to the LOE steering committee on November 13th, 2012. Next steps will be determined at the LOE meeting.

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% of inpatients. Updated Target 12/13: 100% (all remaining patient areas)

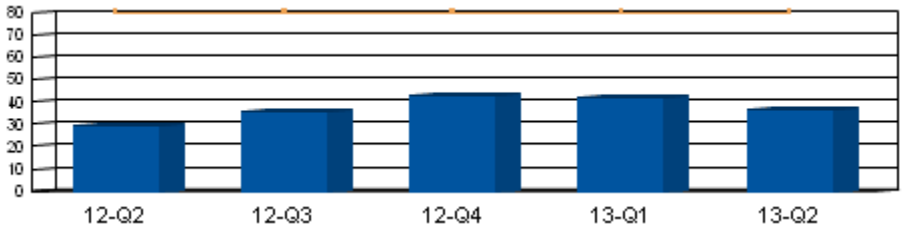
Kingston General Hospital

MS #23

Technology

Discharge summaries are sent to primary care providers within 72 hours

Indicator: Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *



	Actual	Target
12-Q2	29	**80**
12-Q3	36	**80**
12-Q4	43	**80**
13-Q1	42	**80**
13-Q2	37	**80**

Interpretation - Patient And Business:

Second quarter results of 37% represent a 5% decline in performance from the previous quarter. However, this decline is consistent with previous perfromance over the summer months due to new residents and vacation schedules. Overall chart deficiencies remain within target.

Actions & Monitoring Underway to Improve Performance:

Attending physician signature compliance continues to challenge performance. A key barrier relates to the notification of incomplete charts. The initial plan to implement an electronic solution to provide real-time chart deficiency status to physicians has been unsuccessful.
However, the overall reduction in chart deficiencies has enabled existing resources to be dedicated to more frequent physician's notification as per the sanction policy beginning November 1st. Health Information Services and Medical Administration have jointly notified the physician community of this change. The Chief of Staff will also table noncompliance reports at the Joint Quality and Utilization Improvement Committee. Efforts continue to find an automated solution to notify physicians of real-time deficiency status.

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%. QIP Target 12/13: 80%

Strategy milestone # 24

Investment in capital equipment, technology and infrastructure reaches $15 million

Enabler	KGH 2015 outcome	Status
Finances	**Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures**	**Green**
Indicator		
Total Dollars for Capital Equipment, Technology and Infrastructure		

1. **What is our actual performance on each of the indicators for this milestone as listed above?** The hospital currently has the capacity to provide $12.9 million in capital investment in fiscal 2013. The organization has identified in Q3 additional operational savings that will allow the organization to achieve the $15 million target by year-end.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Continued focus on operational performance improvement has made it possible to continue to identify savings to help achieve the target. In this case efforts are supported by our: Operational Performance Department, Finance, and 3SO in cooperation with all hospital programs and services.

3. **Are we on track to meet the milestone by year end?**
Yes as noted above.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** The specific initiative that was completed in Q3 to help achieve this goal for 2012/13 was the completion of an RFP for Cardiac Supplies, which took approximately 6 months to complete and has resulted in a reduction of Cardiac costs by approximately $2.4 million annually.

Kingston General Hospital

MS #24

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Finances	Investment in capital equipment, technology and infrastructure reaches $15 million	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↓
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	Y	Y	G	G	G	↑
		Current Ratio	G	G	G	G	G	↑
		Total Margin	G	G	G	G	G	↑
		Working Capital ($000's)	G	G	G	G	G	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

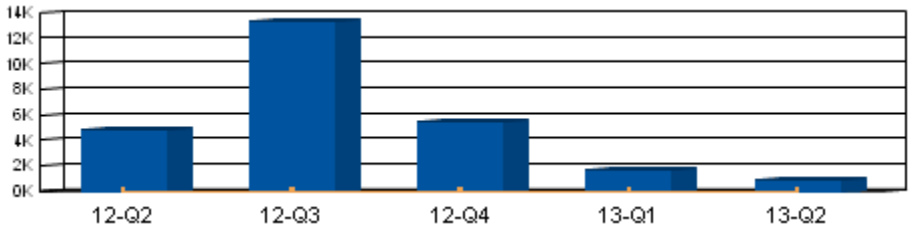
Kingston General Hospital

MS #24

Finances

Investment in capital equipment, technology and infrastructure reaches $15 million

Indicator: Hospital Operations Actual vs. Plan Variance ($000's)



	Actual	Target
12-Q2	4,875	**0**
12-Q3	13,359	**0**
12-Q4	5,532	**0**
13-Q1	1,651	**0**
13-Q2	941	**0**

Interpretation - Patient And Business:

The variance between the actual financial position and budgeted financial position measures the accuracy of the planning model and management's ability to live within the available financial resources.

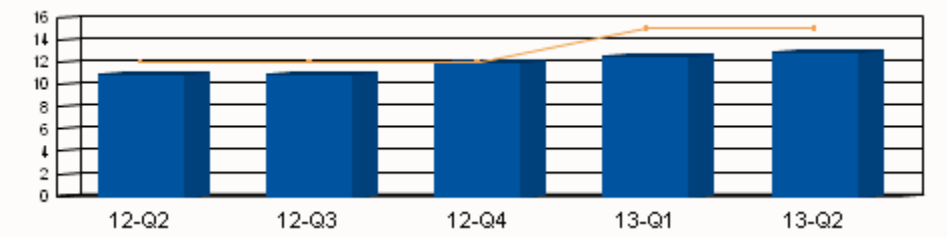
Actions & Monitoring Underway to Improve Performance:

The Q2 results indicate a total margin of $2.6 million. After taking into consideration the variance due to timing between actual and planned expenditures and one-time revenue items, the hospital position is less than $1 million favourable. Favorable variances from position vacancies is offsetting higher than planned overtime, other non-worked compensation, and unplanned overages on medical/surgical supplies and drug costs.

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, Target 12/13: 0

Indicator: Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)



	Actual	Target
12-Q2	11.0	**12**
12-Q3	11.0	**12**
12-Q4	12.0	**12**
13-Q1	12.5	**15**
13-Q2	12.9	**15**

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 $12.9 million in capital investment in fiscal 2013. The organization has identified additional operational efficiency savings that will allow the organization to achieve the $15 million target by year-end.

Definition: Total amount available for capital investment. Calculated as net equipment amortization less long-term loan payments.

Target: Target 11/12: 12M, Target 12/13: 15M

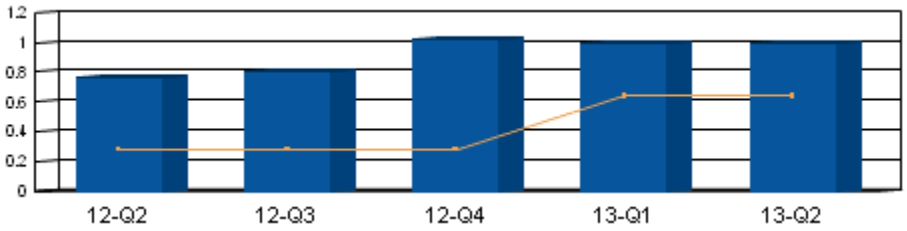
Kingston General Hospital

MS #24

Finances

Investment in capital equipment, technology and infrastructure reaches $15 million

Indicator: Current Ratio



	Actual	Target
12-Q2	0.8	**0.3**
12-Q3	0.8	**0.3**
12-Q4	1.0	**0.3**
13-Q1	1.0	**0.6**
13-Q2	1.0	**0.6**

Interpretation - Patient And Business:

A financially healthy hospital entity is able to provide and sustain services and the physical plant and equipment of the hospital. The current ratio is one of the measures that the public can consider in evaluating the hospital's performance in providing fiscal stewardship over the financial and physical resources entrusted to it by the public. A deteriorating current ratio signals issues, such as an inability to meet current obligations and/or ability to provide capital investment or meet emerging operational pressures. While these realities are true of hospitals like any business enterprise, it must also be acknowledged that hospitals in Ontario are part of a public system and therefore are supported with annual operating funds and cash flow from the Province, which provides a slightly different context.

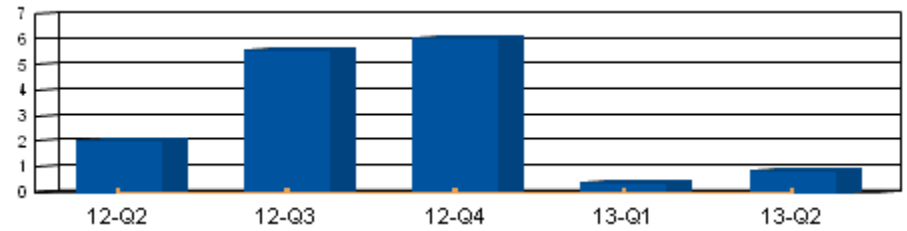
Actions & Monitoring Underway to Improve Performance:

The Q2 current ratio exceeds the fiscal 2012 target. This ratio is expected to decline as resources are expended for the purchase of capital investments in the remainder of the current fiscal year.

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, Target 12/13 0.64

Indicator: Total Margin



	Actual	Target
12-Q2	2.0	**0**
12-Q3	5.6	**0**
12-Q4	6.0	**0**
13-Q1	0.3	**0**
13-Q2	0.8	**0**

Interpretation - Patient And Business:

Note: Year-end target for Total Margin is 0. Q2 Target is -0.43 and has been shaded "green".

The variance between the actual financial position and budgeted financial position measures the accuracy of the planning model and management's ability to live within the available financial resources.

Actions & Monitoring Underway to Improve Performance:

The Q2 results indicate a total margin of $2.6 million. After taking into consideration the variance due to timing between actual and planned expenditures and one-time revenue items, the hospital position is less than $1 million favourable. Favourable variances from position vacancies is offsetting higher than planned overtime, other non-worked compensation, and unplanned overages on medical/surgical supplies and drug costs.

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, Target 12/13: 0

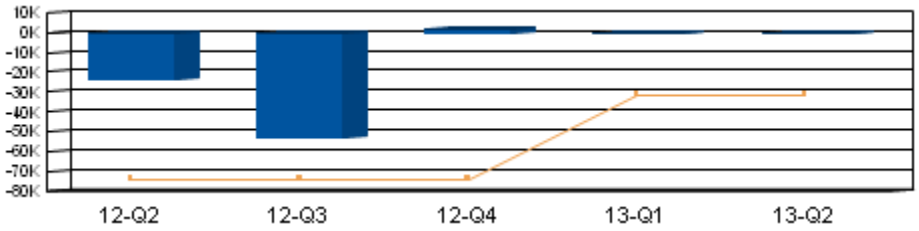
Kingston General Hospital

MS #24

Finances

Investment in capital equipment, technology and infrastructure reaches $15 million

Indicator: Working Capital ($000's)



	Actual	Target
12-Q2	-23,560	**-74000**
12-Q3	-53,191	**-74000**
12-Q4	2,035	**-74000**
13-Q1	-601	**-31500**
13-Q2	-481	**-31500**

Interpretation - Patient And Business:

A financially healthy hospital entity is able to provide and sustain services and the physical plant and equipment of the hospital. Working capital is one of the measures that the public can consider in evaluating the hospital's performance in providing fiscal stewardship over the financial and physical resources entrusted to it by the public. Deteriorating working capital signals issues, such as an inability to meet current obligations and/or ability to provide capital investment or meet emerging operational pressures. While these realities are true of hospitals like any business enterprise, it must also be acknowledged that hospitals in Ontario are part of a public system and therefore are supported with annual operating funds and cash flow from the Province, which provides a slightly different context.

Actions & Monitoring Underway to Improve Performance:

The -$481 thousand working capital deficit reflects the unadjusted position. As capital investment progresses during the fiscal year the working capital deficit will increase. The "adjusted" working capital deficit (excluding funds held for capital investment or other designated purposes) at Q2 is -$52.2 million.

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), Target 12/13: (31500)

Strategy milestone # 25

Staff satisfaction with communication at KGH improves by 20%

Strategic Direction	KGH 2015 outcome	Status
Communication	We continue to engage and report openly and regularly on our progress	Red

Indicator(s)

Staff Satisfaction with Communication at KGH will Improve by 20% based on responses to the statement "I am satisfied with communications in this organization".

1. **What is our actual performance on each of the indicators for this milestone as listed above?**
   Data for this indicator are not available as of this quarter.
2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Many factors contribute to the performance of the indicator for this milestone including communications at the corporate level and between management and front line staff. Research shows that effective, timely, accessible communications with staff contributes to employee engagement. A 20% improvement in satisfaction with communications at KGH would indicate staff is better informed of specific programs and initiatives; prepared to adopt new practices and behaviours, and has a better understanding of new policies, as well as corporate strategic goals.
3. **Are we on track to meet the milestone by year end?**
   Yes.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   To support the organization in achieving this milestone by year end, the communication and public affairs department has established five focused tactics for this year. They include:
   - Build the structure and processes to deliver excellent strategic corporate communications in a timely and effective manner;
   - Create a web strategy to facilitate effective communications at KGH;
   - Design and implement a new corporate website and intranet;
   - Deliver strategic communication counsel to KGH programs and departments
   - Contribute to the development and implementation of a KGH branded, patient-centred environment;
   - Communicate openly and regularly on our progress.

Kingston General Hospital

MS #25

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Communication	Staff satisfaction with communication at KGH improves by 20%	Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization	N/A	N/A	N/A	R	R	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

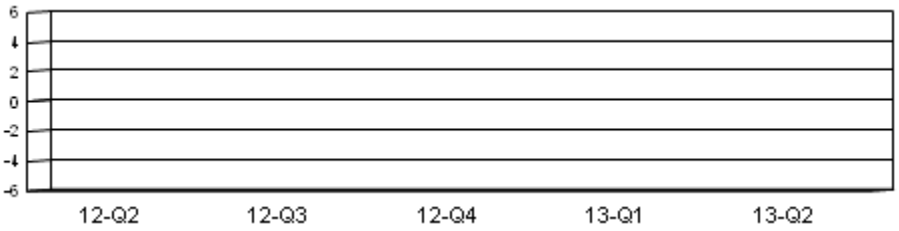
Kingston General Hospital

MS #25

Communication

Staff satisfaction with communication at KGH improves by 20%

Indicator: Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization



	Actual	Target
12-Q2		
12-Q3		
12-Q4		
13-Q1		
13-Q2		

Interpretation - Patient And Business:

Proactive communications programs were developed to engage and inform staff on the Accreditation process; smoking policy; IPE; strategic alignment process to help leaders align their annual plans to the Annual Corporate Plan; CEO Neighbourhood town halls. The Web renewal strategy is now complete and implementation plans are being finalized. Full internet access has been granted to Leaders; KGH social media policy has been approved; wayfinding strategy has been finalized. KGH reach on social media grew by 22.3%, on Twitter and 70% on Facebook.

Definition: Staff satisfaction with communications will be measured through the Worklife Pulse Survey and the engagement survey. Worklife Pulse survey assesses work environment, which is evaluated on a number of aspects including communication, supervision, and learning, involvement in decision making, safety, and worklife balance. Research shows that effective communications with staff, which includes the methods used to facilitate communications between management and frontline staff in a timely fashion and through channels that are accessible by staff, contributes to employee engagement. A 20% improvement in satisfaction with Communications at KGH would indicate staff is better informed of specific programs and initiatives; adoption of new practices and behaviours, and a better understanding of new policies, as well as corporate strategic goals.

Target: 12/13 Target: 47%

Kingston General Hospital

QIP - Fiscal 2012/13 Q2

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
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, How Would You Rate the Care You Received at the Hospital?	G	G	Y	G	N/A	↑
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	N/A	N/A	G	G	
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey *	R	R	R	R	N/A	↑
	Patient safety culture ratings improve by 20%	Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	N/A	N/A	G	G	
		Implementation of Surgical Safety Check List	G	G	G	G	R	↓
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	G	N/A	N/A	N/A	N/A	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	Y	Y	Y	R	↓
		Hospital Standardized Mortality Ratio (HSMR)	G	R	G	N/A	N/A	↑
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	G	G	Y	N/A	↑
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	N/A	N/A	G	G	
	The number of new patients who acquire infections in our hospital is reduced by 10%	Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *	Y	R	Y	Y	Y	↑
		Percent of Sepsis Cases Reviewed by Department Head *	N/A	N/A	N/A	N/A	N/A	
		C-Difficile (Reported Quarterly)	R	R	R	Y	R	↑
		Hand Hygiene Compliance *	Y	G	G	Y	Y	↓
	KGH overall average length of stay is better than expected length of stay	Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	G	Y	Y	↑

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
	The emergency department wait time for admitted patients is improved by 20%	Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	Y	G	G	R	Y	↓
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	R	Y	N/A	N/A	N/A	↑
		90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	G	Y	R	↓
		Percent of ED Consults Meeting Target Time (Time Between Consult Requested in ED and Consultant Arrival ED) *	N/A	N/A	N/A	N/A	N/A	
Technology	Discharge summaries are sent to primary care providers within 72 hours	Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *	R	R	R	R	R	↓

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

Kingston General Hospital

Strategy Performance Report - Fiscal 2012/13 Q2

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
KGH 2015	100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award	100% Accreditation Canada Requirements Met	N/A	N/A	N/A	G	G	
	Quality Improvement Plan Targets are Met	Number of Quality Improvement Plan Goals for Change Met	N/A	N/A	N/A	Y	Y	
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	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%)	G	G	G	G	N/A	↑
	Patient safety culture ratings improve by 20%	Percent of Staff Surveyed Who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	N/A	N/A	R	N/A	N/A	
	Medication reconciliation is completed for every internal medicine program inpatient at admission	Medication Reconciliation is Completed for Every Internal Medicine Program Inpatient at Admission	G	G	G	G	Y	↓
	The number of new patients who acquire infections in our hospital is reduced by 10%	Number of New Cases of Hospital Acquired Infection	Y	Y	R	G	R	↓
	KGH overall average length of stay is better than expected length of stay	Average # ALC Patients per Day	R	G	G	R	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	G	Y	Y	↑
	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	G	Y	R	↓
	Clinical services meet the provincial wait time target	Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	R	R	R	R	Y	↑
	Cancer Care Ontario access to care indicators are met	Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)	R	R	R	R	N/A	↓
		Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met	R	R	R	R	R	↑
Bring to life new models of interprofessional care and education	Automation of interprofessional assessment-and-adverse-reaction documents is complete (e-doc project)	Automation of Interprofessional Assessment & Adverse Reaction Documents is Complete as Part of the E-Doc Project	N/A	N/A	N/A	N/A	N/A	
	Workplan to fulfill interprofessional-education competencies is completed	Number of Interprofessional Organizational Educational Competencies Are Met	N/A	N/A	N/A	R	Y	

			12-Q2	12-Q3	12-Q4	13-Q1	13-Q2	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	8% Increase of Externally Funded Research Dollars at KGH	G	G	G	N/A	G	↑
		Square Footage of Clinical Research Space at KGH	N/A	N/A	N/A	N/A	N/A	
Increase our focus on complex-acute and specialty care	Clinical Services Roadmap initiatives launched	KGH Participation in Clinical Services Roadmap Initiatives	G	G	G	G	G	↑
	Target service volumes are met	Percent of Contracted Volumes Achieved	Y	G	G	G	G	↓
	Evidence-based guidelines are adopted in 12 clinical areas	Number of Clinical Areas that have Implemented Open Source (OS)	R	G	G	G	G	↑
People	Overall staff satisfaction ratings improve by 20%	Staff Satisfaction Ratings Will Improve By 20% based on Responses of Agree and Strongly Agree to the Question "Overall I am Satisfied With This Organization"	N/A	N/A	R	N/A	N/A	
	Health and Safety Scorecard targets are met	Number of Health & Safety Scorecard Target Indicators Met	N/A	N/A	N/A	G	Y	
	Employee engagement action plans are in place at all team levels	Employee Engagement Action Plans at Corporate and Team Level are Complete	N/A	N/A	N/A	N/A	R	
Processes	100% of KGH managers complete continuous improvement training	Percent of Management Staff Completing Mandatory Process Improvement Training	R	R	R	G	G	↑
Facilities	Phase 2 redevelopment functional programming commences	Phase 2 Redevelopment Project Targets are Met	N/A	N/A	N/A	G	G	
	Carpets are removed from 75% of patient areas	Quarterly Carpet Removal Targets are Met	G	G	G	Y	G	↑
Technology	Discharge summaries are sent to primary care providers within 72 hours	Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - QIP *	R	R	R	R	R	↓
Finances	Investment in capital equipment, technology and infrastructure reaches $15 million	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	G	↓
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	Y	Y	G	G	G	↑
Communication	Staff satisfaction with communication at KGH improves by 20%	Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization	N/A	N/A	N/A	R	R	

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

				12-Q1	12-Q2
Health and Safety	Health & Safety		OHS - # MOL Orders Issued	N/A	G
			OHS - 21 Day Management Response to JHSC Identified Hazards	R	R
			OHS - Cases of Possible/Confirmed Cases of Occupational Illness Reported to MOL	G	G
			OHS - Completion of Pre-Placement Health Screening	G	G
			OHS - Days Lost Due to Workplace Injury/Illness	G	Y
			OHS - High Risk Occupational Exposures Reported to MOL	Y	G
			OHS - Incidence of all MSI Injuries (MSI's)	Y	R
			OHS - Incidence of Needlestick Injuries (NSIs)	Y	R
			OHS - Incident Investigations Complete	R	R
			OHS - JHSC Monthly Workplace Inspections	G	G
			OHS - Lost Time Injury/Illness Claims	G	G
			OHS - Management Workplace Inspections	R	R
			OHS - Mandatory Safety Training	Y	Y
			OHS - MOL Reported Critical Injury	G	G

				12-Q1	12-Q2
Health and Safety	Health & Safety		OHS - MSI Lost Time Injury Claims (LTIs)	G	G
			OHS - Respirator Fit Testing & Training Completion	R	R
			OHS - WSIB Healthcare Claims	Y	R
			OHS - WSIB NEER Performance Index - 2008	Y	N/A
			OHS - WSIB NEER Performance Index - 2009	Y	N/A
			OHS - WSIB NEER Performance Index - 2010	G	N/A
			OHS - WSIB NEER Performance Index - 2011	G	N/A

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - # MOL Orders Issued

	Actual	Target
12-Q1	0	0
12-Q2	0	0

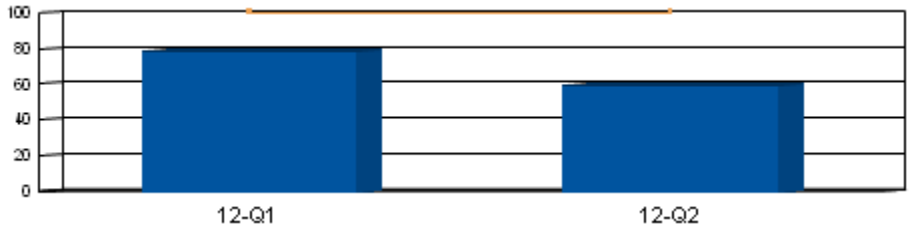
Interpretation - Patient And Business:

1 MOL visit in Q2 in follow up to a Workplace Violence complaint. No orders issued.

Definition: Orders of compliance issued to the Employer by the Ministry of Labour (MOL) when contraventions of the Occupational Health & Safety Act and/or its Regulations are identified at the time of a site visit/inspection.

Target: 2012/13 Target: 0

Indicator: OHS - 21 Day Management Response to JHSC Identified Hazards



	Actual	Target
12-Q1	78	100
12-Q2	59	100

Interpretation - Patient And Business:

For month of July, no management responses received back.

Definition: Where the hospital's Joint health & Safety Committee (JHSC) identifies hazards and makes recommendations for their control/correction, a response from management outlining the action to be taken is required within 21 days in accordance with the Occupational Health & Safety Act.

Target: 2012/13 Target: 100%

Indicator: OHS - Cases of Possible/Confirmed Cases of Occupational Illness Reported to MOL

	Actual	Target
12-Q1	0	0
12-Q2	0	0

Definition: This indicator measures the number of occupationally acquired illnesses reported by workers to the Employer; notice to the Ministry of Labour (MOL) is required within 4 days as per the Occupational Health & Safety Act for all occupational illnesses whether confirmed or not.

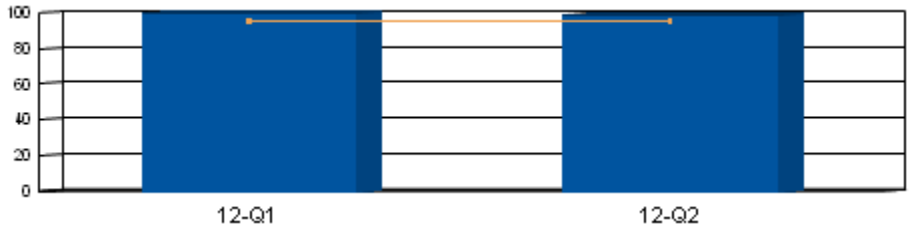
Target: 2012/13 Target: 0

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - Completion of Pre-Placement Health Screening

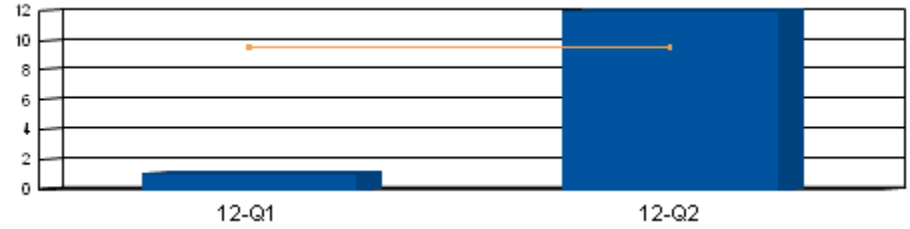


	Actual	Target
12-Q1	100	**95**
12-Q2	99	**95**

Definition: Completion of pre-placement medical screening in all new employees to the hospital; pre-screening is a condition of employment at KGH and required under the Public Hospitals Act.

Target: 2012/13 Target: 95%

Indicator: OHS - Days Lost Due to Workplace Injury/Illness



	Actual	Target
12-Q1	1	**≤ 9.5**
12-Q2	12	**≤ 9.5**

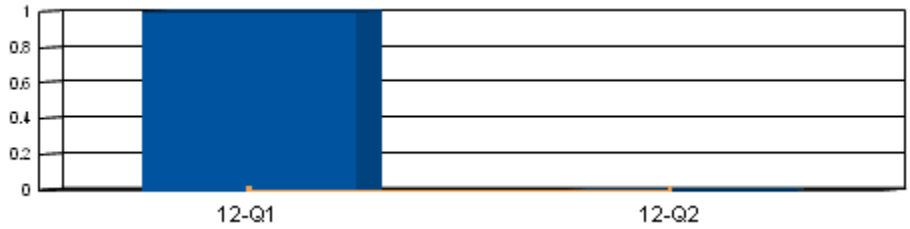
Interpretation - Patient And Business:

2 lost time injuries; one resulted in 7 days of lost time and the other in 5 days.

Definition: Initial number of days lost from work due to a new workplace injury or illness; this does not include lost time that may be incurred later on once the worker has returned to work.

Target: 2012/13 Target: 10% Reduction (38 Days)

Indicator: OHS - High Risk Occupational Exposures Reported to MOL



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

Interpretation - Patient And Business:

Definition: Number of occurrences where one or more workers have had an unprotected occupational exposure(s) to a potentially infectious agent and the agent has the potential to cause occupational illness in the worker(s).

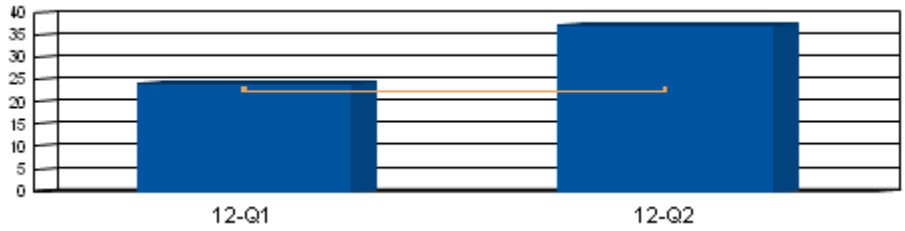
Target: 2012/13: 0

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - Incidence of all MSI Injuries (MSI's)



	Actual	Target
12-Q1	24	≤ 22.5
12-Q2	37	≤ 22.5

Interpretation - Patient And Business:

17 MSIs reported in July, 11 in Aug, and 9 in Sept.

12 of these MSIs resulted in WSIB healthcare claims and 1 in a WSIB lost time injury claim.

57% of the MSIs occurred during patient handling activities.

Programs with highest MSI incidence: SPA 7, Medicine 6, ER 5.

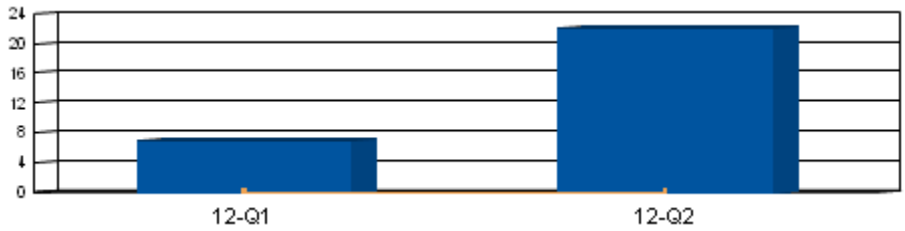
Actions & Monitoring Underway to Improve Performance:

MSI prevention program (specifically Safe Patient Handling Program) currently being evaluated. Should have recommendations for improvement in 6 weeks.

Definition: Total number of occupational related musculoskeletal injuries (MSIs) reported by workers in the Safe Reporting Tool.

Target: 2012/13 Target: <=90

Indicator: OHS - Incidence of Needlestick Injuries (NSIs)



	Actual	Target
12-Q1	7	0
12-Q2	22	0

Interpretation - Patient And Business:

36% of NSIs caused by butterflies during blood collection.

Improper activation of safety mechanisms on needles was a factor in nearly 50 % of the NSIs.

Actions & Monitoring Underway to Improve Performance:

Butterfly Collection set has been converted to a safer Push Button Butterfly effective October 2012.
New Nexiva IV catheter being trialed Oct 2012
Needle Safety Training via the LMS under development for al clincial staff

Definition: Total number of needlestick injuries reported by workers in the Safe Reporting Tool; does not include other non-needle sharps-related injuries.

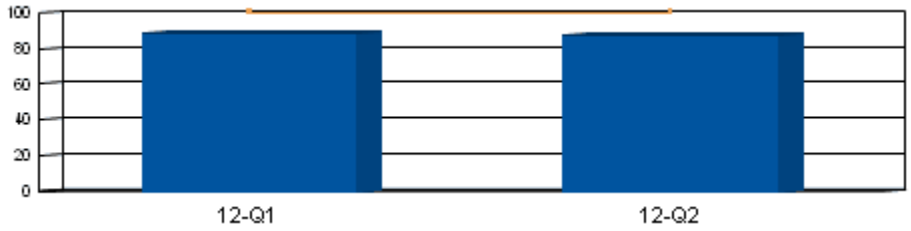
Target: 2012/13: 0

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - Incident Investigations Complete



	Actual	Target
12-Q1	89	**100**
12-Q2	87	**100**

Interpretation - Patient And Business:

Consistent with previous quarter.

July 87%
Aug 84%
Sept 90%

Actions & Monitoring Underway to Improve Performance:

OHSW has initiated 1:1 sessions with managers/supervisors to review incident investigation expectations, tools, and information that is required.

Definition: Completion rate for management/supervisor investigation of workplace incidents/injuries reported by employees in the Safe Reporting Tool. Investigation ensures work related hazards are understood and controlled to prevent incident/injury recurrence.

Target: Target 2012/13: 100%

Indicator: OHS - JHSC Monthly Workplace Inspections

	Actual	Target
12-Q1	100	**100**
12-Q2	100	**100**

Definition: Compliance by the Joint Health & Safety Committee (JHSC) in the completion of workplace inspections; physical inspections of the workplace are required monthly as per the Occupational Health & Safety Act.

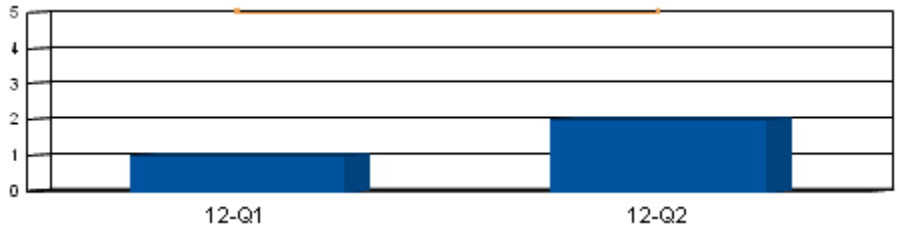
Target: Target 2012/13: 100%

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - Lost Time Injury/Illness Claims



	Actual	Target
12-Q1	1	< 5
12-Q2	2	< 5

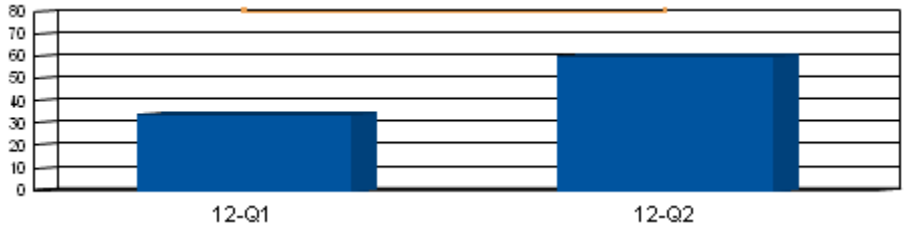
Interpretation - Patient And Business:

1 LTI dermatitis related and other was MSI in nature.

Definition: Number of claims reported to the Workplace Safety & Insurance Board (WSIB) where a worker lost one or more shifts due to any workplace injury or illness, beyond the first day of injury/illness. Not all lost time claims are necessarily approved by the WSIB.

Target: Target 2012/13: <= 19

Indicator: OHS - Management Workplace Inspections



	Actual	Target
12-Q1	34	≥ 80
12-Q2	60	≥ 80

Interpretation - Patient And Business:

Improvement from Q1.

Actions & Monitoring Underway to Improve Performance:

Management Accountability for quarterly inspections recently reviewed at Leadership XChange sessions.
OHSW now sends reminders when quarter nearing an end and area inspection has not been received.

Definition: Management/supervisor compliance in the completion of quarterly inspections required as part of the hospital's Hazard Recognition & Control program.

Target: Target 2012/13: 80%

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - Mandatory Safety Training

	Actual	Target
12-Q1	93	100
12-Q2	93	100

Interpretation - Patient And Business:

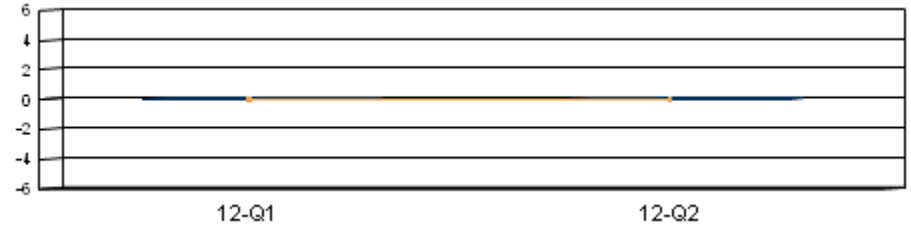
WHMIS at 90%, Workplace Violence & Harassment Prevention at 96% and MSI Prevention at 90%.

Similar compliance as Q1

Definition: Employee completion of health & safety training deemed as mandatory; this includes Workplace Violence & Harassment Prevention, Musculoskeletal Injury (MSI) Prevention, and for some workers, WHMIS training.

Target: Target 2012/13: 100%

Indicator: OHS - MOL Reported Critical Injury

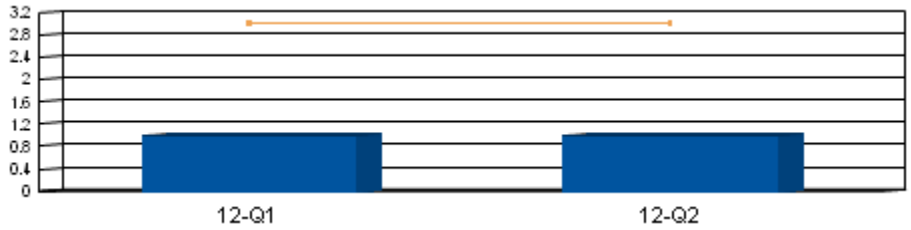


	Actual	Target
12-Q1	0	0
12-Q2	0	0

Definition: Injuries that meet the definition of "critical injury" under the Occupational Health & Safety Act that require notice to the Ministry of Labour (MOL).

Target: Target 2012/13: 0

Indicator: OHS - MSI Lost Time Injury Claims (LTIs)



	Actual	Target
12-Q1	1	< 3
12-Q2	1	< 3

Definition: Number of claims reported to the Workplace Safety & Insurance Board (WSIB) where a worker lost one or more shifts due to a workplace musculoskeletal injury (MSI), beyond the first day of injury/illness. Not all MSI lost time claims are necessarily approved by the WSIB.

Target: Target 2012/13: 10

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - Respirator Fit Testing & Training Completion

	Actual	Target
12-Q1	85	100
12-Q2	87	100

Interpretation - Patient And Business:

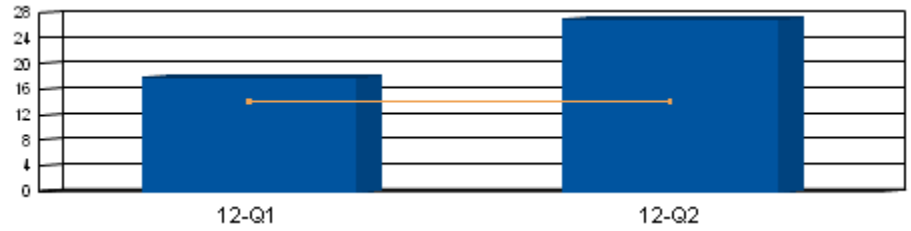
Actions & Monitoring Underway to Improve Performance:

Employees now receive an email reminder 60 days in advance of their fit testing & training coming due and again at 30 days if not yet completed. Once expired, monthly reports are issued to Management.

Definition: Completion of employee fit testing and training for those workers who may be required to don a tight fitting respirator as part of their work assignment; is required every 2 years.

Target: Target 2012/13: 100%

Indicator: OHS - WSIB Healthcare Claims



	Actual	Target
12-Q1	18	< 14
12-Q2	27	< 14

Interpretation - Patient And Business:

July-9 claims; Aug-13 claims; Sept- 5 claims

Main type of incident resulting in health care claims was MSIs (12).

Environmental Services have the highest incidence of health care claims (22%).

Definition: Number of claims reported to the Workplace Safety & Insurance Board (WSIB) where a worker sought health care treatment from a health care provider, as a result of a workplace injury or illness. Excludes first aid and assessments completed as part of the hospital's post exposure surveillance program. Not all health care claims are necessarily approved by the WSIB.

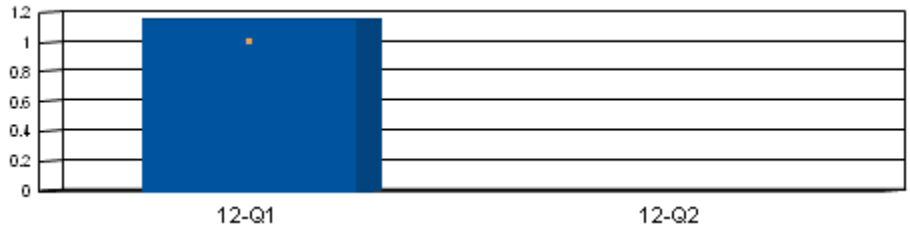
Target: Target 2012/13: <= 54

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2008

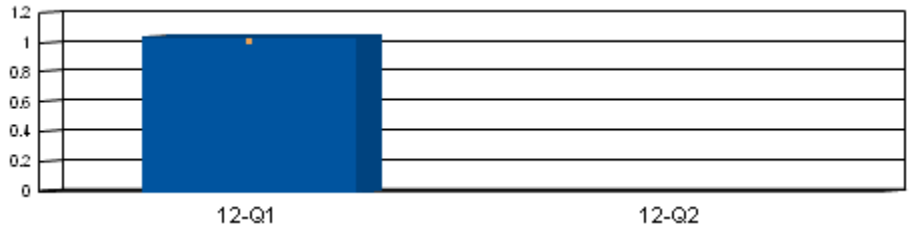


	Actual	Target
12-Q1	1.15	≤ 1
12-Q2		

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

Indicator: OHS - WSIB NEER Performance Index - 2009

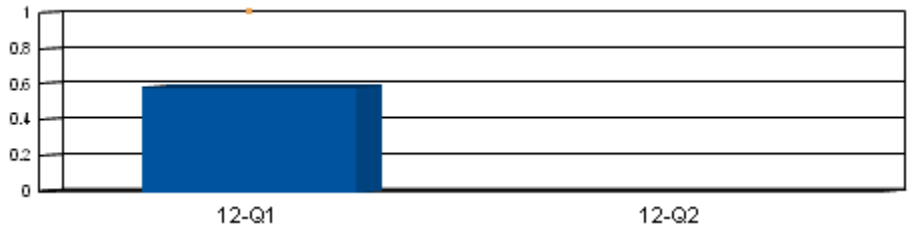


	Actual	Target
12-Q1	1.04	≤ 1
12-Q2		

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

Indicator: OHS - WSIB NEER Performance Index - 2010



	Actual	Target
12-Q1	0.58	≤ 1
12-Q2		

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected cost;; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

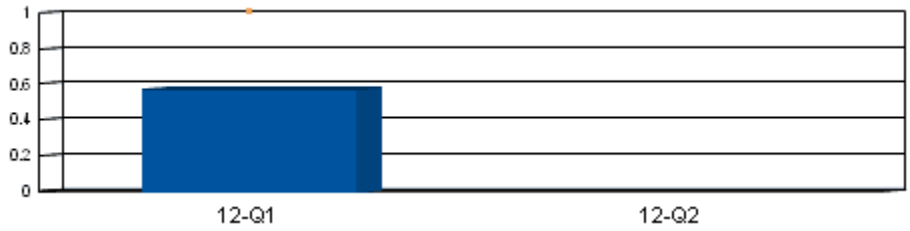
Target: Target 2012/13: < 1

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2011



	Actual	Target
12-Q1	0.57	**≤ 1**
12-Q2		

Definition: Is an indicator of hospital performance in relation to workplace injury/illness costs; specifically, it is a ratio of actual costs to expected costs; where actual cost are > expected costs, the performance index will be greater than 1; where actual costs are < expected costs, the performance index will be less than 1. Is calculated for previous 4 accident years.

Target: Target 2012/13: < 1

Kingston General Hospital

Occupational Health and Safety Scorecard
Q2 Fiscal 2012-13

Status:

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