fiscal 2012-2013 **Q3**

3rd quarter ended December 31, 2012

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

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KGH Master Performance Report
Q3 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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- 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 57**

- 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 62**

- 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 65**

- 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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People

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Finances

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Communication

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 milestone was achieved with the conclusion of the Sept 2012 survey and the award of Accreditation with Exemplary Status.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The work associated with Accreditation Canada standards and Required Organization Practices is ideally embedded in the ongoing work of the organization. Activities continue with ROP's such as medication reconciliation, patient falls, etc. With the renewed approach to patient safety and quality, the focus on performance against measures aligned to the standards of AC, and improvement activities, will be strengthened.

3. **Are we on track to meet the milestone by year end?** The milestone has been met.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** As above (2).

Kingston General Hospital

MS #01

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

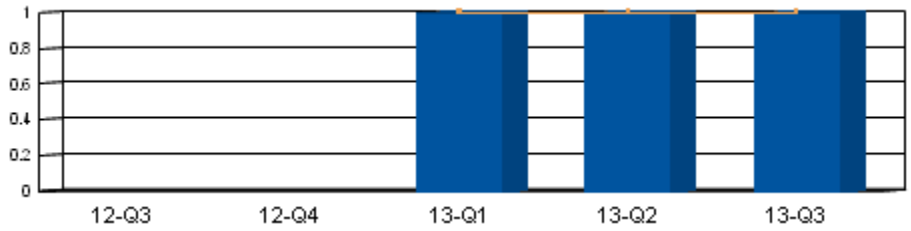
Kingston General Hospital

MS #01

KGH 2015

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

Indicator: 100% Accreditation Canada Requirements Met



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

Interpretation - Patient And Business:

The milestone was achieved with the conclusion of the Sept 2012 survey and the award of Accreditation with Exemplary Status.

Actions & Monitoring Underway to Improve Performance:

The work associated with Accreditation Canada Standards and Required Organizational Practices (ROP) are ideally embedded in the ongoing work of the organization. Activities continue with ROP's, such as medication reconciliation, patient falls. With the renewed approach to patient and safety, the alignment and focus on Accreditation standards/ROP will be strengthened.

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

Quality Improvement Plan targets are met

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

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?

NB: Two Planned Improvement Initiatives for the 2012/13 QIP have been retired: Quarterly review of sepsis (now rolled into mortality reviews) and ED consult times (data not available) leaving 12 indicators being assessed.

Performance in Q3 has shown an improvement in 3 indicators going yellow to green Hand hygiene compliance has reached target; Overall ALOS vs ELOS has reached target; and 30 day readmission to KGH fell below target. All four red indicators are trending for improvement (Food satisfaction; 3 phases of Surgical Safety Checklist; e-discharge in 72 hrs; mortality review by departments).

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

Program and Infection Prevention Control leadership on service awareness of indicators and awareness of quality of care focus (eg. Check lists).

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?

SPA program focus on Surgical Safety Checklist (3 phases) data to services. Implementation of in-box in the PCS system to increase the e-discharge indicator. Antibiotic usage increased during Q2 due to the influenza outbreak. In a non-outbreak state, the antibiotic stewardship program is hoped to maintain the improvements seen Q1 and Q2.

Kingston General Hospital

MS #02

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

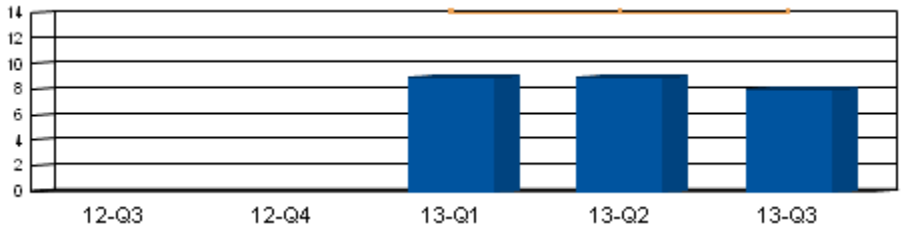
Kingston General Hospital

MS #02

KGH 2015

Quality Improvement Plan Targets are Met

Indicator: Number of Quality Improvement Plan Goals for Change Met



	Actual	Target
12-Q3		
12-Q4		
13-Q1	9	**14**
13-Q2	9	**14**
13-Q3	8	**14**

Interpretation - Patient And Business:

Performance in Q3 has shown an improvement in 3 indicators going yellow to green. Hand hygiene compliance has reached target; ALOS vs. ELOS has reached target; and 30 day readmission to KGH fell below target. All four red indicators are trending for improvement (Food satisfaction; 3 phases of Surgical Safety Checklist; e-discharge in 72 hrs; mortality review by departments). Mortality reviews although completed have not met the timelines imposed upon the Departments. Antibiotics dispensed during the last quarter increased but coincides with the influenza outbreak.

NB: Two Planned Improvement Initiatives for the 2012/13 QIP have been retired: Quarterly review of sepsis and ED consult times leaving 12 indicators being assessed.

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

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 Q2 data, received Jan 25, 2013 reports that the inpatient overall satisfaction at KGH is 76.3% relative to 74.9 in the last quarter, and to the current 75.6% Ontario Teaching average. For overall care received, KGH achieved 96.2% relative to 94.2 in the last quarter, and the current 94.3 Ontario Teaching average.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Programs and services are deliberate in focusing on improving processes and appear to be proactive in engaging patient perspectives with design of change. The profile of KGH's work at a national and international level supports staff awareness, pride and involvement. The alignment of program and service level tactics and PDSA cycles to the performance metrics and strategy, also ensures focus on the goal of Outstanding Care, Always. Efforts continue to ensure consistency and sustainability.

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?** Patient led forums help to profile the work on patient engagement and improvement initiatives that transform patient experience. All programs will hold a patient led feedback forum by fiscal year end. By December 2012, 2 formal feedback forums, with the Medicine and Emergency Programs, were held. Sessions are scheduled with 1 in January , 4 in February (with two programs being included in one forum), and 1 with date to be confirmed. Feedback thus far is positive from both patient and provider perspectives, and each forum has at least one improvement initiative resulting from the discussion. The proposed redesign of the supports for quality and safety , with alignment of patient experience consultants to support the use of information and the improvement processes will be further support to this milestone.

Kingston General Hospital

MS #03

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

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

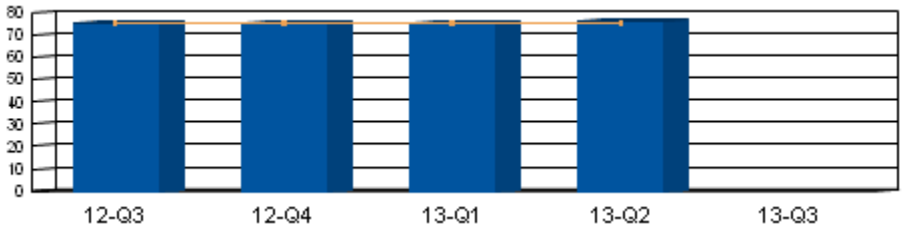
Kingston General Hospital

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-Q3	75	**75**
12-Q4	75	**75**
13-Q1	75	**75**
13-Q2	76	**75**
13-Q3		

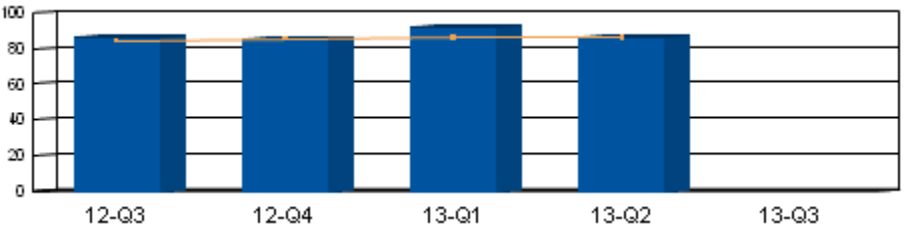
Interpretation - Patient And Business:

The current overall acute care satisfaction as with the previous quarter is on par with our target.
KGH is currently scoring on par with the ON Teaching Hosp Av on 5 of the 8 dimensions of care. Respect for patient preferences, physical comfort and continuity& transition are between 3 and 4% above the ON Teaching Hospital average.

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

Interpretation - Patient And Business:

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

KGH is meeting the 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

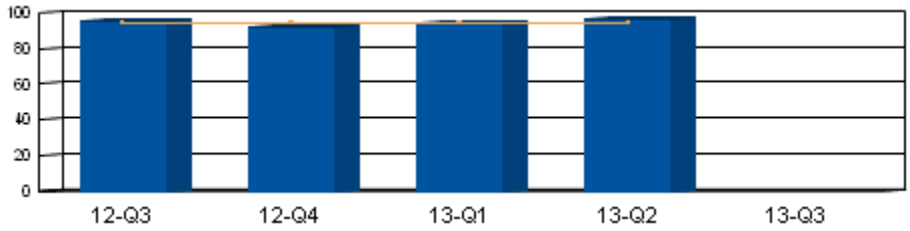
Kingston General Hospital

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



	Actual	Target
12-Q3	95	**94**
12-Q4	92	**94**
13-Q1	94	**94**
13-Q2	96	**94**
13-Q3		

Interpretation - Patient And Business:

Based upon the Q2 results, received Jan 2013, the positive percent score including good, very good and excellent, for KGH is 96.2% compared to 94.2% in the last reported quarter, and to the Ontario teaching avg. in Q2 of 94.3%. Results are attributed in part to the focus on the part of programs and services in aligning activities to the strategy and transforming the patient experience, and to the active engagement of patients/families in the design of improvements.

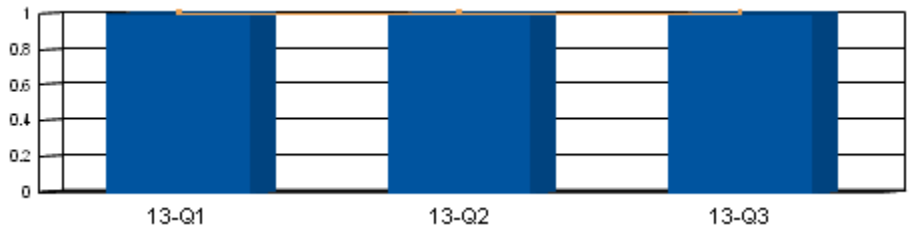
Actions & Monitoring Underway to Improve Performance:

As the work on each annual corporate plan unfolds, there will continue to be alignment of work to the strategic direction of transforming the patient experience. The teams will be supported in making improvements with the training about LEAN methodology, and with resources such as the newly created Patient Experience Consultant roles within the safety/quality infrastructure. Patient led feedback sessions will also enable teams to learn of specific opportunities through the experience of specific patient populations (ie one forum per program minimum 2x per year).

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**
13-Q3	1	**1**

Interpretation - Patient And Business:

2 of 9 programs have completed formal patient led feedback sessions (Medicine and ED). Lessons learned from the forums have been raised with staff and action plans are developed to sustain or remedy processes and behaviors which impact the patient experience. These are being approached using the process excellence education (LEAN methodology and PlanDoStudyAct - PDSA cycles). Sessions have been scheduled for remaining programs with 1 in January, 4 in February (one is shared by 2 programs) and 1 yet to be confirmed. Feedback thus far is positive from patient and staff.

Actions & Monitoring Underway to Improve Performance:

Support plan for completion of the feedback session by end of March 2013 and build expectation and accountability for continuation into next year.

The proposed redesign of the supports for quality and safety, with alignment of patient experience consultants to support the use of information, and design of improvement processes will be further support.

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

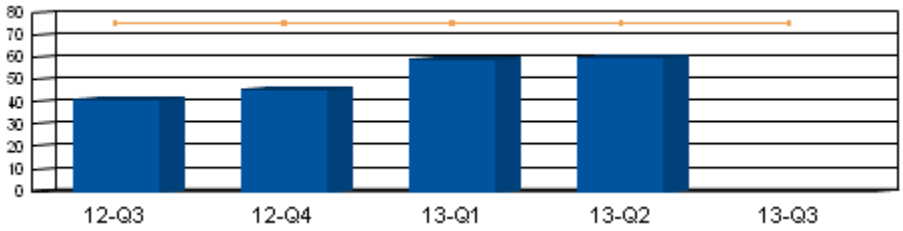
Kingston General Hospital

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-Q3	41	**75**
12-Q4	46	**75**
13-Q1	59	**75**
13-Q2	60	**75**
13-Q3		**75**

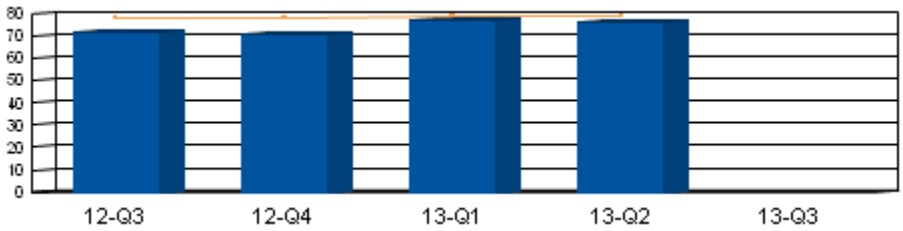
Interpretation - Patient And Business:

KGH results for this quarter showed a 1% increase in satisfaction nearing our target of 75%.
Our result of 60% 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-Q3	72	**78**
12-Q4	71	**78**
13-Q1	77	**79**
13-Q2	76	**79**
13-Q3		

Interpretation - Patient And Business:

The question supports the overall acute care patient experience. KGH result this quarter continues to be within striking distance of meeting the ON Teaching Hosp Av.

Actions & Monitoring Underway to Improve Performance:

Improvement from last quarter is noted and can built upon by the guiding principles of Patient and Family Centred Care as well as the introduction of AIDET principles across programs.

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

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 for this milestone, 4 are green, 1 yellow and 3 red. Two red indicators (mortality reviews by departments and the 3 phases of the surgical safety checklist) are trending positively. The milestone indicator, the Patient Safety Culture Survey rating, is measured annually and therefore the red status is based on survey from the previous fiscal year.

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

   SPA leadership focus on accountability for the surgical checklist has shown the positive trending for both indicators.

3. **Are we on track to meet the milestone by year end?** No

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   A decision has been made to delay the Patient Safety Survey until fall to allow the Patient Safety, Quality and Risk program design change to begin implementation. It is of note that 2 red indicators could show significant improvements based on planned actions. MAC's JQUIC Committee will reinforce Clinical Departmental accountability for timely delivery on Mortality Reviews and the SPA leadership will continue to focus on service level data to support Surgical Safety Checklist improvements.

Kingston General Hospital

MS #04

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	R	N/A	N/A	N/A	
		Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	N/A	G	G	G	
		Implementation of Surgical Safety Check List	G	G	G	G	G	↑
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	R	R	N/A	N/A	N/A	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	Y	R	R	R	↑
		Hospital Standardized Mortality Ratio (HSMR)	R	G	N/A	N/A	N/A	↑
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	G	Y	Y	N/A	↓
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	N/A	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

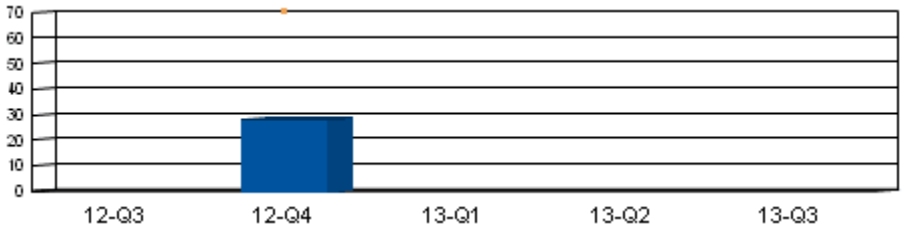
Kingston General Hospital

MS #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-Q3		
12-Q4	28	70
13-Q1		
13-Q2		
13-Q3		

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

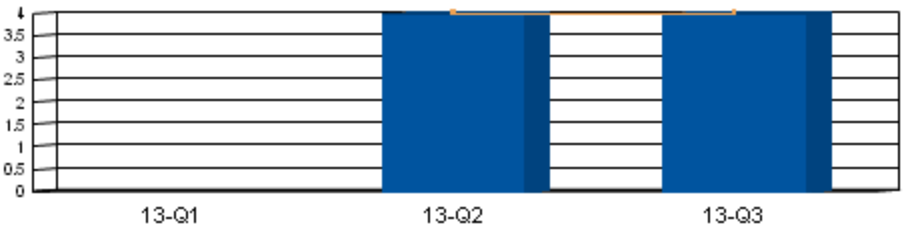
The question on the Patient Safety Culture Survey reads;

"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
13-Q3	4	4

Interpretation - Patient And Business:

Quarterly targets quickly met by programs to implement checklists as part of their safety and quality initiatives.

Actions & Monitoring Underway to Improve Performance:

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

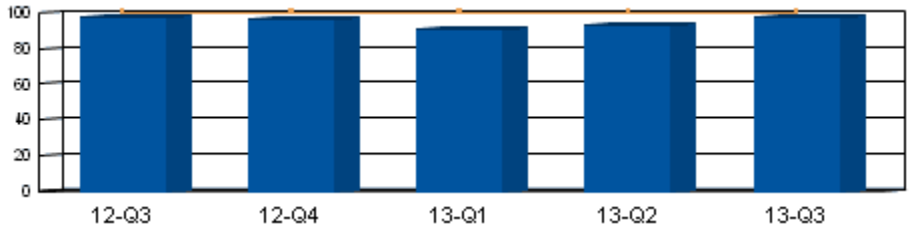
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

Indicator: Implementation of Surgical Safety Check List



	Actual	Target
12-Q3	97	**100**
12-Q4	96	**100**
13-Q1	91	**100**
13-Q2	93	**100**
13-Q3	98	**100**

Interpretation - Patient And Business:

The continued positive trending for this indicator is a result of the staff comfort with the transition from the ORSOS system to the new PICIS electronic operating room documentation system.

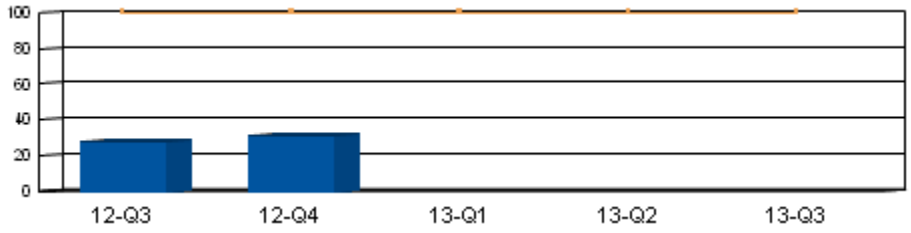
Actions & Monitoring Underway to Improve Performance:

SPA program leadership will continue to monitor results and work with individual surgical service teams on opportunities to improve.

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-Q3	28	**100**
12-Q4	31	**100**
13-Q1		**100**
13-Q2		**100**
13-Q3		**100**

Interpretation - Patient And Business:

Our mortality review process focuses on the deaths that are identified through the HSMR calculation. Because we only just received the HSMR case level data for Fiscal 11/12 Q4, the results for Q3 Fiscal 12/13 are not yet available.

Actions & Monitoring Underway to Improve Performance:

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

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

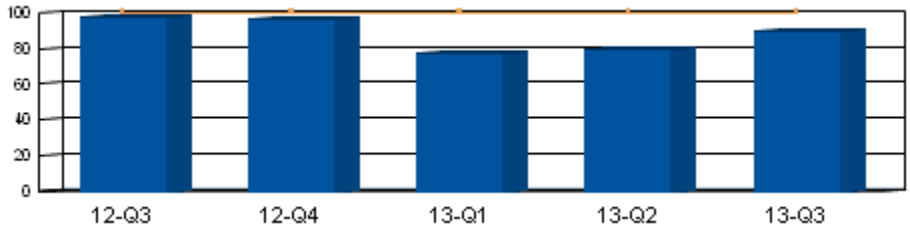
Kingston General Hospital

MS #04

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

Patient safety culture ratings improve by 20%

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



	Actual	Target
12-Q3	97	**100**
12-Q4	96	**100**
13-Q1	77	**100**
13-Q2	80	**100**
13-Q3	90	**100**

Interpretation - Patient And Business:

Substantial improvement noted in this quarter as the program and staff transition from the ORSOS electronic system to the new PICIS system for the monitoring of the surgical safety checklists (SSCL) in the Operating Room. Overall the compliance for all services to complete the 3 phases of the surgical safety checklist for non-urgent activity is the following: Briefing -99%, Timeout- 98% and the final Debrief - 93%. Focus on urgent/emergent activity SSCL reporting is required to meet the overall average target of 100%.

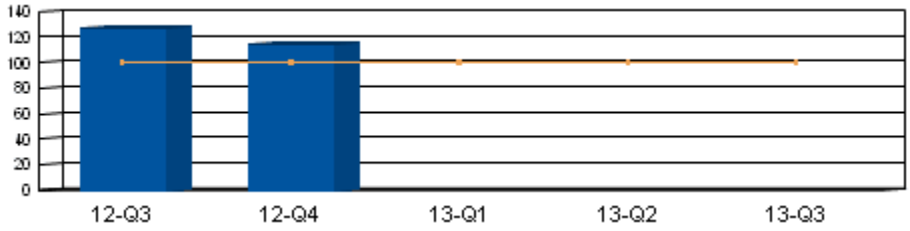
Actions & Monitoring Underway to Improve Performance:

Ongoing education and monitoring will be conducted by the program to assist the following services in improving their compliance in completing the 3 phases of SSCL reporting for urgent activity in the operating room.

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%

Indicator: Hospital Standardized Mortality Ratio (HSMR)



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

Interpretation - Patient And Business:

No data available until February 2013.

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

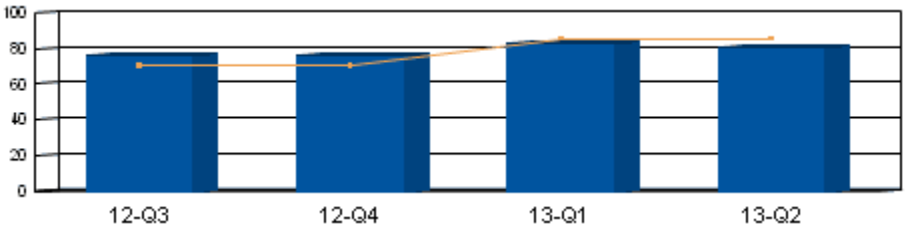
Kingston General Hospital

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 Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *



	Actual	Target
12-Q3	76	**70**
12-Q4	76	**70**
13-Q1	83	**85**
13-Q2	81	**85**

Interpretation - Patient And Business:

The 81% represents the feedback which is received through the NRC + Picker Patient Satisfaction Survey which is conducted on discharge. We continue to work with our staff in improving our discharge cleaning.

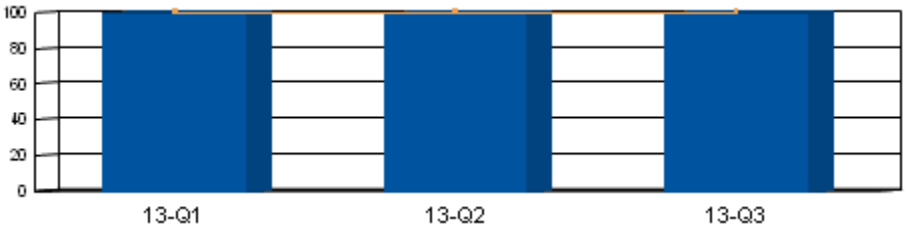
Actions & Monitoring Underway to Improve Performance:

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%

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



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

Interpretation - Patient And Business:

Five (5) Critical Incident Reviews were held under the Quality of Care Information Act (QCIPA) from 2012 Oct-Dec. There were a total of 18 resulting recommendations. Seven (7) of these are complete and the outstanding eleven (11) are in progress, many currently part of ongoing improvement cycles.

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%

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**	**Green**

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 98% 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 98%.

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 support devoted to the Pharmacy program will ensure progress. It is worth noting that there was a detailed presentation at the Quality Patient Care committee of the board on this issue. Pharmacy leadership spoke about the risks going forward, particularly as it relates to the existing workload of pharmacists. Ongoing support to pharmacy resources will be essential in order to ensure progress. A rollout plan was developed at the outset that will help guide future implementation. Supporting pharmacy to analyze workflow redesign will be a priority.

Kingston General Hospital

MS #05

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	Y	G	

Indicates improving performance to target over the past 5 quarters 

Indicates worsening performance to target over the past 5 quarters 

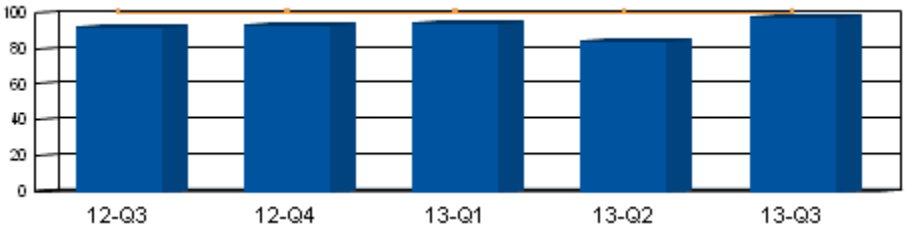
Kingston General Hospital

MS #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-Q3	92	**100**
12-Q4	93	**100**
13-Q1	94	**100**
13-Q2	84	**100**
13-Q3	98	**100**

Interpretation - Patient And Business:

Indicator on target, highest score to date.

The hospital is well positioned to start reporting this indicator as part of the KGH Corporate Performance Reports for Fiscal 13/14.

Actions & Monitoring Underway to Improve Performance:

The Medication Reconciliation Charter has laid out its 5 year implementation plan. Clearly successful in the medicine program, further implementation will require the need for further resource allocation.

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?**
   This milestone remains Red for Q3, however, the supporting indicators are showing improvement. Key to this improvement is the decrease in C difficile and Central Line infections in addition to the improvements in Hand Hygiene Compliance. It is of note that Hand Hygiene compliance exceeded the target by 1%, reaching 96% in December.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Infection Prevention and Control redesign to focus on education has been a key factor in decreased C difficile 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?**

   We are confident we will achieve the target by year end because of antibiotic dispensing, the continued fall of C difficille , and improvements in hand hygiene compliance. Overall, our environment is cleaner and the chance of getting an infection is lower than it used to be. Our Westec environmental audits continue to show gains. Most recently the OR achieved a 87% compliance rating. Infection Prevention and Control working with programs will continue supporting education on hospital acquired infections especially regarding compliance with MRSA screening. Antibiotic Stewardship will continue early implementation as resources support it.

Kingston General Hospital

MS #06

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	R	G	R	R	↓
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days *	R	Y	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	Y	R	Y	↑
		C-Difficile (Reported Monthly)	R	R	R	R	Y	↑
		Hand Hygiene Compliance *	G	G	Y	Y	G	↑
		Central Line Bloodstream Infections	G	G	G	Y	G	↑
		MRSA (Methicillin-resistant Staphylococcus Aureus)	G	G	Y	Y	R	↓
		VRE (Vancomycin-resistant Enterococcus)	G	G	R	R	R	↑
		Ventilator Associated Pneumonia	G	R	R	G	G	↑
		Surgical Site Infection (SSI) Prevention	Y	Y	G	G	Y	↓
		External Environmental Audits by Westech	N/A	N/A	Y	Y	N/A	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

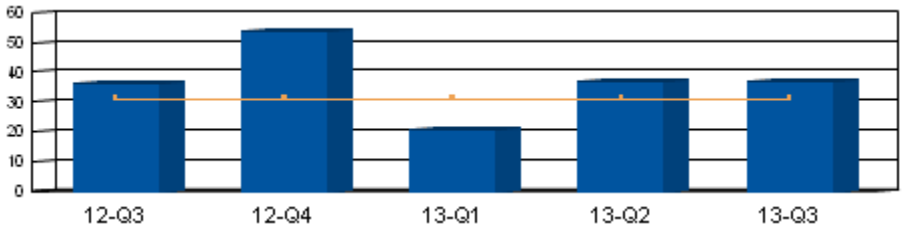
Kingston General Hospital

MS #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

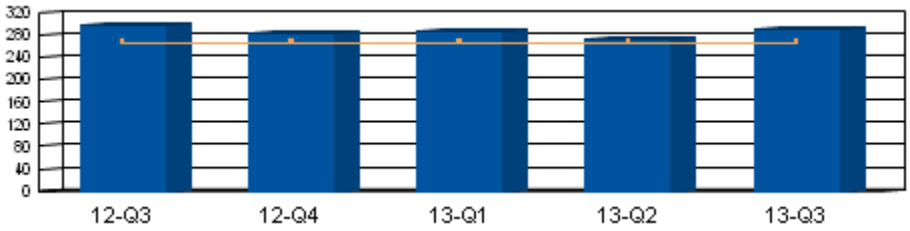


	Actual	Target
12-Q3	36	**31**
12-Q4	54	**31**
13-Q1	21	**31**
13-Q2	37	**31**
13-Q3	37	**31**

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-Q3	299	**267**
12-Q4	285	**267**
13-Q1	287	**267**
13-Q2	272	**267**
13-Q3	290	**267**

Interpretation - Patient And Business:

Reduced targeted antibiotic use has been maintained but still not at target. Despite that we have not seen jumps in non-targeted antibiotics to date suggesting some mitigation of increasing antibiotic use often seen during this quarter annually. At the same time this has happened at a time where staffing resources in ASP are still not optimal.

Actions & Monitoring Underway to Improve Performance:

The Antibiotic Stewardship program was launched mid Q2 into the Critical Care environment and sporadically in other wards. Additional Pharmacy resources to support the program are critical to more widespread implementation. Although budgeted in the programs proposal Pharmacy Residents are in limited supply.

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

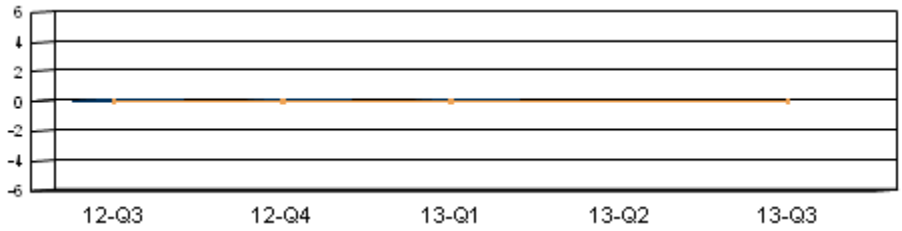
Kingston General Hospital

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-Q3	0	**0**
12-Q4	0	**0**
13-Q1	0	**0**
13-Q2		**0**
13-Q3		**0**

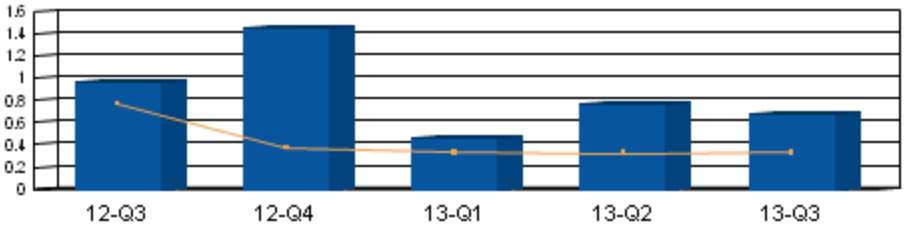
Interpretation - Patient And Business:

This indicator has been folded into 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-Q3	0.97	**0.77**
12-Q4	1.45	**0.37**
13-Q1	0.46	**0.33**
13-Q2	0.77	**0.32**
13-Q3	0.68	**0.33**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.68 cases per 1000 patient days; a decrease from the previous quarter. In October there were 12 cases of CDI. In November, there were 6 cases of CDI and in December there were 7 cases giving us a total of 25 cases for the quarter in comparison to quarter 2, where we had 28 cases and 31 cases in quarter 3 of 2011/2012. Overall our CDI rates are trending downwards.

Business Perspective: Measures implemented previously to ensure prompt initiation of Contact Precautions including the appropriate use of PPE (gowns and gloves) and strict hand hygiene continue to be monitored and assessed. The newly drafted CDI Order Set had been forwarded to the Antibiotic Stewardship Committee for review and is now being forwarded to the Infection control Committee for endorsement. The order set's intent is to assist physicians in managing patients identified with CDI and improve outcomes.

Actions & Monitoring Underway to Improve Performance:

KGH has not had a CDI outbreak since Q1 F 11/12, the longest duration in last 5 years. IPC redesign and leadership has been a key component in this success along with the new ASP.

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

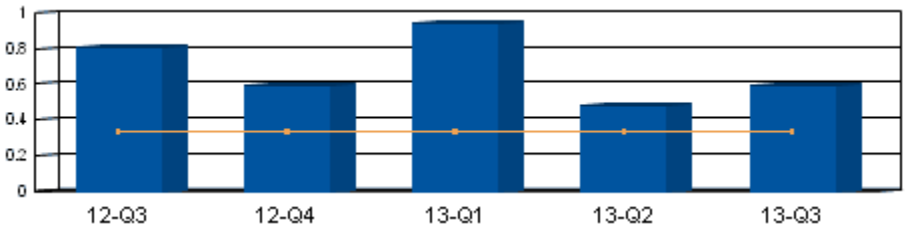
Kingston General Hospital

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-Q3	0.81	**0.33**
12-Q4	0.59	**0.33**
13-Q1	0.94	**0.33**
13-Q2	0.48	**0.33**
13-Q3	0.59	**0.33**

Interpretation - Patient And Business:

Please note the last 5 quarters are monthly values (Aug - Dec 2012). Sustained and stabilized CDI rates with no outbreak declarations.

Actions & Monitoring Underway to Improve Performance:

KGH has not had a CDI outbreak declared since Q1 F 11/12, the longest duration in the last 5 years. IPC redesign and leadership has been a key component in this success. Institution of an ASP program has helped to stabilize antibiotic use and impacted on stability of CDI rates. .

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

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

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

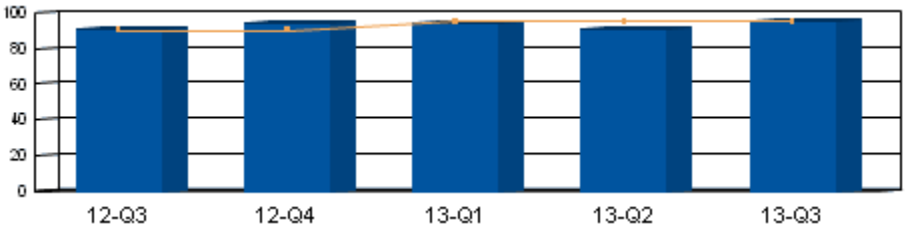
Kingston General Hospital

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: Hand Hygiene Compliance *



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

Interpretation - Patient And Business:

Patient Perspective: In October, November and December patients continued to receive hand hygiene education from nursing and IPAC Service. 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 reduce the incidence of nosocomial infections overall.

Business Perspective: In Quarter 3, the 96.8% compliance rate was the result of 2239 observations, where 1447 HCP observed. There were 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 education to the new tool for the 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 continuing to meet our target.

Actions & Monitoring Underway to Improve Performance:

Target has been reached! A 10% improvement in compliance over the last 7 quarters (F11/12 Q1). A multidisciplinary, multifaceted approach to a complex change in culture.

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%

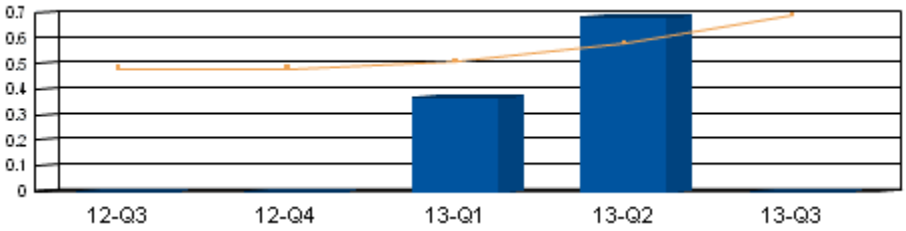
Kingston General Hospital

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-Q3	0.00	**0.48**
12-Q4	0.00	**0.48**
13-Q1	0.37	**0.51**
13-Q2	0.68	**0.58**
13-Q3	0.00	**0.69**

Interpretation - Patient And Business:

No cases this quarter which is attributed to increase compliance with CLI bundle and close monitoring of Safety Coordinator in Critical Care and Advanced Practice Nurse double checking data accuracy against patient records.

Actions & Monitoring Underway to Improve Performance:

Continue to monitor. Overall trend within target but small Ns can cause rates with yellow caution.

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

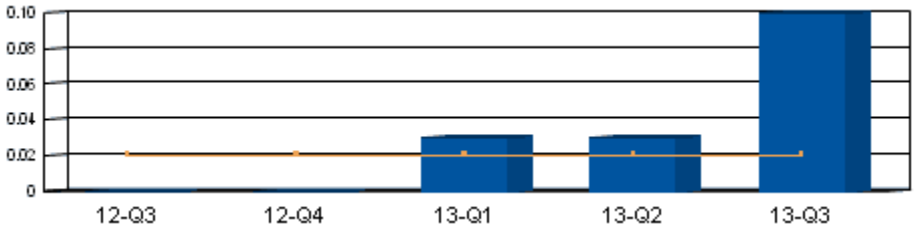
Kingston General Hospital

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: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
12-Q3	0.00	**0.02**
12-Q4	0.00	**0.02**
13-Q1	0.03	**0.02**
13-Q2	0.03	**0.02**
13-Q3	0.10	**0.02**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.08 per 1000 patient days which represents three cases. All three cases occurred in patients who were known to be colonized for MRSA prior to the development of the bacteremia.

Business Perspective: Additional attention to admission screening compliance will be a focus in the coming months and will assist in ensuring we are identifying patients with MRSA and placing them in precautions on admission. Hand hygiene compliance also contributes to our efforts to achieve our target.

Actions & Monitoring Underway to Improve Performance:

Further reinforcement of IPC standards and protocols will be paramount to ensure MRSA is being screened and isolated appropriately.

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

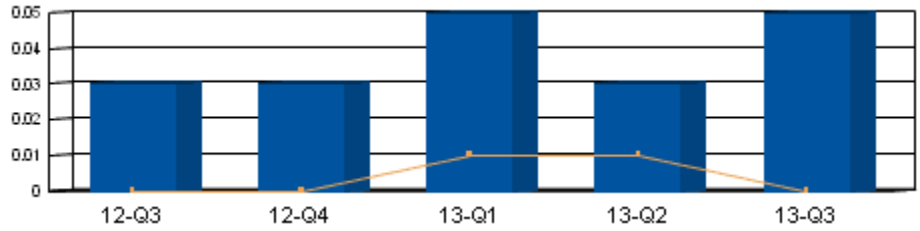
Kingston General Hospital

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: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
12-Q3	0.03	**0**
12-Q4	0.03	**0**
13-Q1	0.05	**0**
13-Q2	0.03	**0**
13-Q3	0.05	**0**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0.05 which represents only two cases.

Business Perspective: KGH IPAC continues to surveillance of VRE. All clinical isolates are reviewed for an infectious process. Bacteremias are reported as required to the province.

Actions & Monitoring Underway to Improve Performance:

Executive focus on this indicator awaits assessment and analysis of data in light of a practice change in management of colonized VRE patients July 2012 concurrently with TOH, UHN and LHSC.

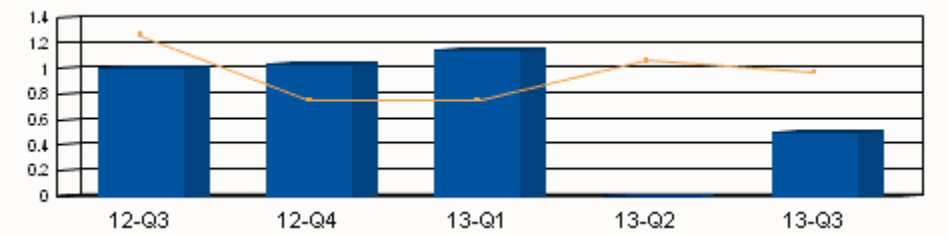
Definition: Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. If a person has an infection caused by VRE, such as a blood 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

Indicator: Ventilator Associated Pneumonia



	Actual	Target
12-Q3	1.00	**1.26**
12-Q4	1.03	**0.75**
13-Q1	1.14	**0.75**
13-Q2	0.00	**1.06**
13-Q3	0.50	**0.97**

Interpretation - Patient And Business:

rate of .5 is reflective of one case of VAP in CSU which is a rare occurrence given most ventilation in CSU is less than 48 hours and does not meet criteria of VAP definition.

Actions & Monitoring Underway to Improve Performance:

monitor for further occurrences and trends despite within target.

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

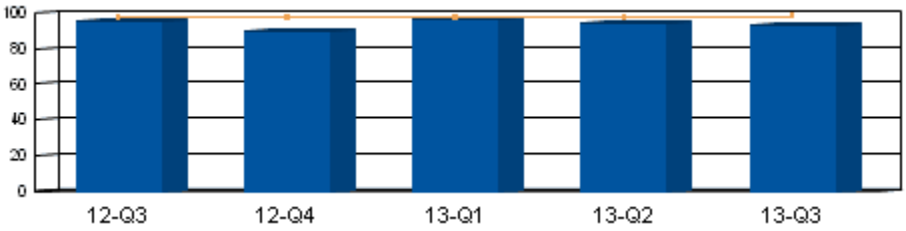
Kingston General Hospital

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: Surgical Site Infection (SSI) Prevention



	Actual	Target
12-Q3	95	**97**
12-Q4	90	**97**
13-Q1	96	**97**
13-Q2	94	**97**
13-Q3	93	**98**

Interpretation - Patient And Business:

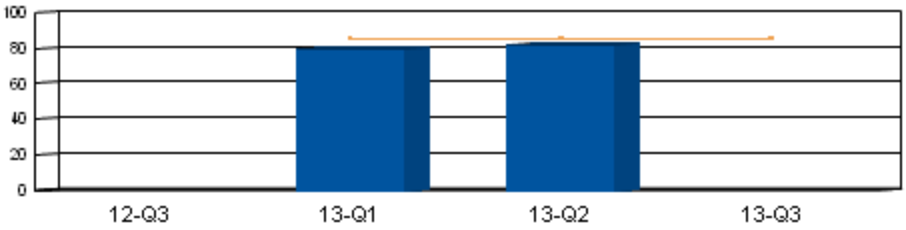
Patient Perspective: The rate of appropriate timing of prophylactic antibiotic administration for patients undergoing orthopedic procedures this quarter was 93%, below the target of 98%.

Business Perspective: Combined efforts between IPAC and the SPA Program to ensure accurate documentation of the prophylactic antibiotic administration continues to ensure we work towards achieving our target.

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

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

Indicator: External Environmental Audits by Westech



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

Interpretation - Patient And Business:

We continue to identified areas that require improvements, particularly the OR, Imaging, and clinical labs. Managers continue to work with our staff on the Westech standards.

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%

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	Green

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?** While there has been a slight increase in the actual acute average length of stay (6.5 to 6.7), it remains below the expected length of stay (ELOS) by 0.8 days which is now meeting target. The five services that have not yet achieved the ELOS are Gastroenterology, Neurology, Neurosurgery, Ob/Gyn and Radiation Oncology. It is worth noting that collectively these 5 services are only over by 168 days or the equivalent of 26 cases (.01%) for the period.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Programs continue to focus on tactics that improve aspects of care and patient flow. The Patient Flow Task Force, which reviews LOS trends and actions plans, has been expanded to include representation from Providence Care in support of understanding and focusing on this point of transition from KGH. Performance also remains challenged by resources of patients requiring ALC or patriation/repatriation to regional/provincial centres.

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?** There are good processes to support collaboration with key partners such as CCAC and hospital partners, and these continue to evolve. Out of the PFTF, and using insights gained through the concurrent review process, a tactic team is being created with direct provider and patient engagement along the continuum of hospitals and CCAC to identify and address opportunities to avoid ALC (ambulation; staffing etc), earlier transitions (consultation/communication), etc.

Kingston General Hospital

MS #07

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	G	G	R	R	R	↓
		Percent ALC Days	G	G	G	R	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	Y	Y	G	↑
		Percent of Clinical Services Meeting or Exceeding ELOS Target	R	R	R	R	R	↓
		Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	Y	G	G	Y	↓
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	G	G	R	Y	G	↑
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	Y	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

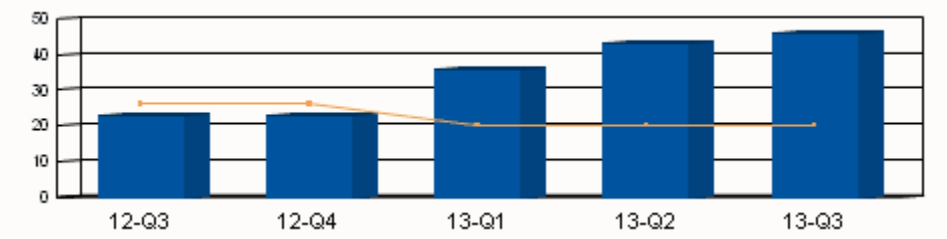
Kingston General Hospital

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: Average # ALC Patients per Day



	Actual	Target
12-Q3	23	**26**
12-Q4	23	**26**
13-Q1	36	**20**
13-Q2	43	**20**
13-Q3	46	**20**

Interpretation - Patient And Business:

The average climbed to 46 in Q3. Patients designated ALC for long term care continue to account for approximately 65% of the total number of ALC patients. Rehab and complex continuing care designations make up approximately 20% of the total, with the remaining 15% spread across 4 destination categories.

In Q3 there were 50 patients admitted to Home First. These were patients at risk of becoming ALC-LTC who were discharged home, thereby avoiding an ALC designation.

External factors including availability of beds and crisis placements from the community continue to affect patient flow to LTC facilities.

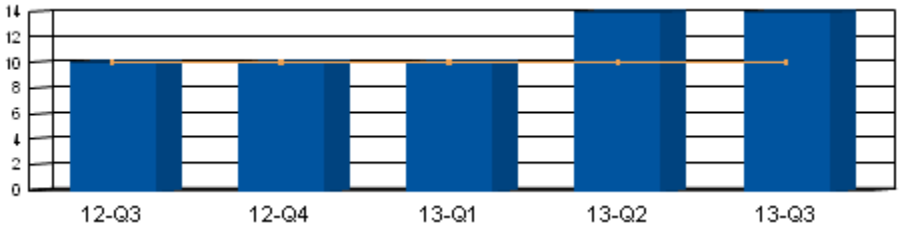
Actions & Monitoring Underway to Improve Performance:

Review of ALC patients in October and November - report released in January 2013. Activities underway to review both internal and external processes in an attempt to reduce conversion of patients from acute to ALC status, and to promote efficient transfer to external facilities. In addition, discussions are in progress with the SELHIN regarding gaps in availability of resources in the community to deal with patients with behavioral concerns i.e. unable to be admitted to LTC facilities or home, but who do not require the services of an acute inpatient hospital.

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-Q3	10	**10**
12-Q4	10	**10**
13-Q1	10	**10**
13-Q2	14	**10**
13-Q3	14	**10**

Interpretation - Patient And Business:

This figure reflects the increased number of ALC patients in the organization; specifically patients waiting for transfer to a long term care (LTC) facility. The average number of ALC patients per day waiting for LTC was 29. The target for total number of ALC patients is 20. Given that the majority of ALC LTC patients are > 65 years of age, this indicator will remain high until the average number of ALC patients is reduced.

Actions & Monitoring Underway to Improve Performance:

Review of ALC patients in October and November - report released in January 2013. Activities underway to review both internal and external processes in an attempt to reduce conversion of patients from acute to ALC status, and to promote efficient transfer to external facilities. In addition, discussions are in progress with the SELHIN regarding gaps in availability of resources in the community to deal with patients with behavioural concerns i.e. unable to be admitted to LTC facilities or home, but who do not require the services of an acute inpatient hospital.

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%

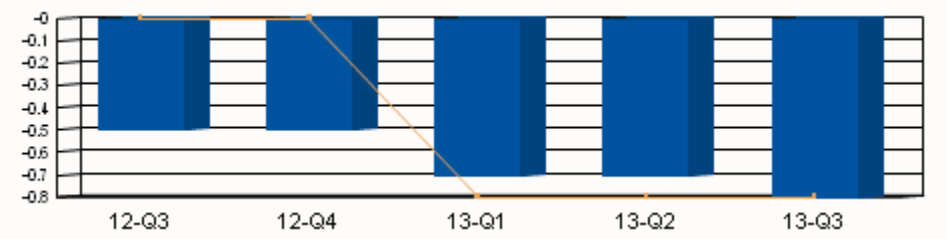
Kingston General Hospital

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

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q3. The -0.8 day variance for Q3 (fiscal 12/13) indicates that our overall actual length of stay remains below (or better) than our expected length of by 0.8 of a day, 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 5 of 18 services to achieve expected length of stay. They are the services of Gastroenterology, Neurology, Neurosurgery, Obs and Gyn, Radiation Oncology.

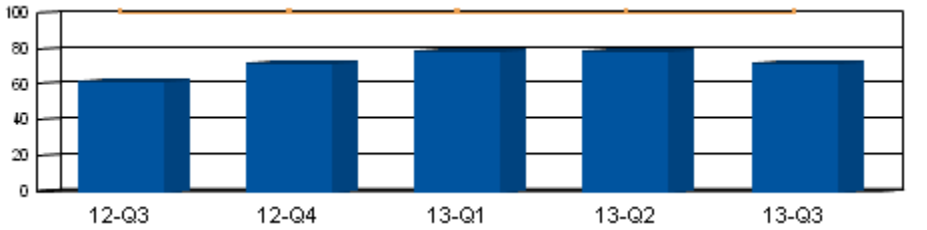
Actions & Monitoring Underway to Improve Performance:

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

Interpretation - Patient And Business:

As of Q3 (fiscal 12/13), 72 percent of services (13 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, Neurosurgery, Obs/Gyn, Radiation Oncology.

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%

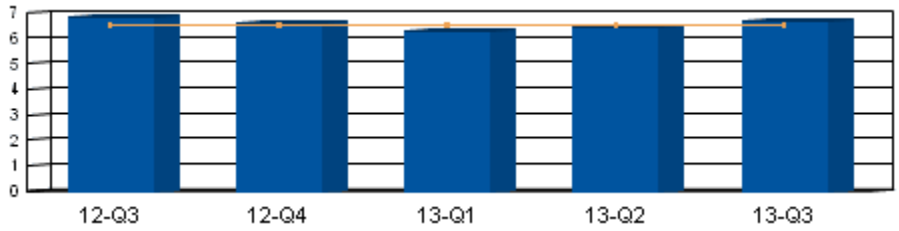
Kingston General Hospital

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-Q3	6.8	**6.5**
12-Q4	6.6	**6.5**
13-Q1	6.3	**6.5**
13-Q2	6.4	**6.5**
13-Q3	6.7	**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).

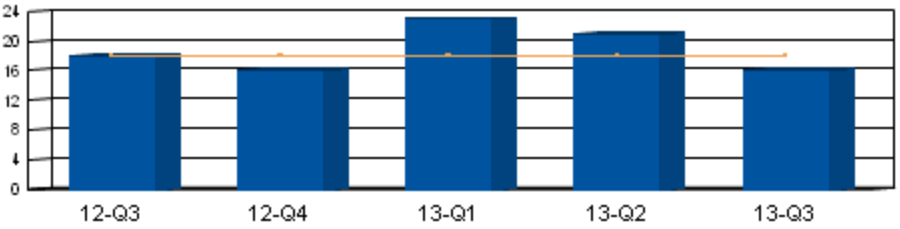
Actions & Monitoring Underway to Improve Performance:

The average length of stay for Q3 at 6.7 days is slightly above the target of 6.5 days. It is worth noting that at the same time our average length of stay compared to expected length of stay is .8 days below our expected. There continues to be tremendous efforts placed on this achieving this target though the implementation of a variety of tactics 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

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



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

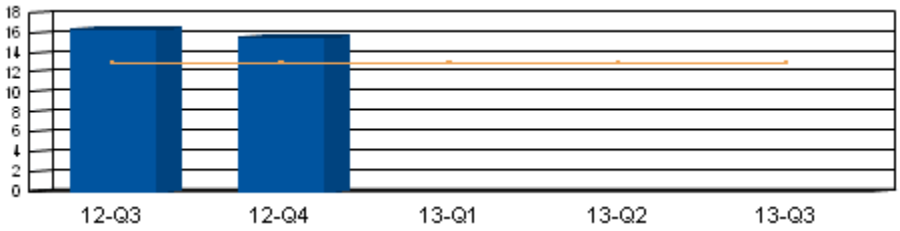
Kingston General Hospital

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



	Actual	Target
12-Q3	16.3	**12.9**
12-Q4	15.6	**12.9**
13-Q1		**12.9**
13-Q2		**12.9**
13-Q3		**12.9**

Interpretation - Patient And Business:

Data provided by SE LHIN is not available.

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%

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?** The trend for this indicator has been unfavorable since Q1 of this fiscal year. As of Q3, the 90th percentile ED wait time for all patients admitted from the ED was 34.5 hours, which is 12.5 hours more than the ambitious target of 22 hours set by the SE LHIN. As of December 2012 (Apr to Dec fiscal12/13), 19% or 7,861 of all ED visits were admitted (which is slightly higher than our peers). Of those 7,861 people, 5985 (76%) were admitted within the 22hr target. Of the 1876 patients that exceeded the 22 hrs target, 1613 (86%) were admitted by 48 hrs. Of the remaining 263 patients, 197 were admitted by 72 hrs. Only 65 patients waited beyond 72 hrs.
2. **What are the contributing factors to the current performance of the indicators for this milestone?** The ED has experienced an increase in activity with visits being 10.8% higher year to date than budget. There is not an identifiable change in population or condition that accounts for this increase. Similarly, there is an increase in the number of admissions, particularly aligned to the Medicine program, resulting in an impact on utilization. Compounding this activity increase, the number of ALC patients has increased and limits throughput (Q3 average – 46 relative to target of 20), and the number waiting for LTCH alone exceeds the target). Regional partners report similar increases as reason for delay in patriation/repatriation
3. **Are we on track to meet the milestone by year end?** No. Based upon increased frequency and duration of Code Gridlock as overall activity in January, and given the gap between performance and target, this milestone will not be met by March 2013.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Within KGH, improvement cycles are focusing on discharge prediction, room turnover, ad hoc discharge lounges, patient navigator positions. Collaboration on regional / provincial initiatives such as Home First, and the CAHO Move On will focus on mobilization as means to prevent falls/ ALC designation and support further reduction in LOS. Departments /programs with above ELOS are being approached and supported with opportunities to support patient flow. Ways to support needs in the community will be explored, and the MOHLTC HealthLinks will be supported as a means of improving partnership with primary care providers to avoid ED visits and readmissions. The ACP with tactics will ensure ongoing focus on improvements.

Kingston General Hospital

MS #08

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	Y	R	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	Y	G	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

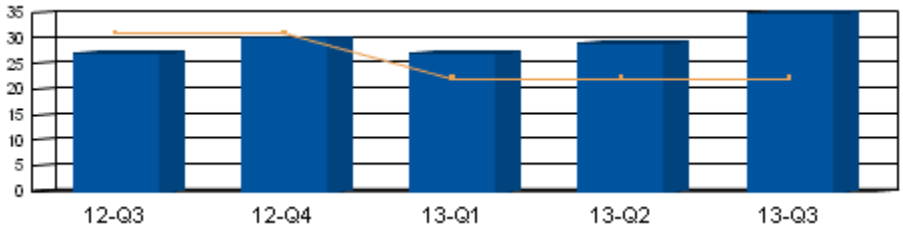
Kingston General Hospital

MS #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-Q3	27	**31**
12-Q4	30	**31**
13-Q1	27	**22**
13-Q2	29	**22**
13-Q3	35	**22**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for all admitted patients has been trending negatively since Q1. The Q3 result of 34.5 hours is 12.5 hours longer than the 22 hour target. Ninety percent of all patients admitted through the ED wait up to 34.5 hours to be moved to an inpatient bed. Ten percent wait longer than this.

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 the Patient Flow Task Force meetings.
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 the 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. Additional bed capacity has been created in OPPU during periods of high pressure in order to decant admitted patients out of the ED.

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-Q3		
12-Q4		
13-Q1		
13-Q2		
13-Q3		

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

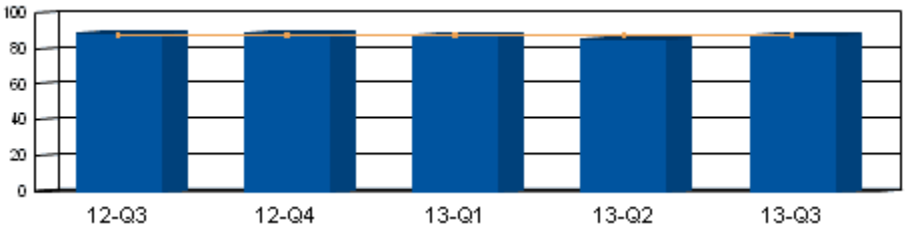
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on the Q3 results, the ED has sustained the improvement in the ED wait time meeting the 87% target for non-admitted, high acuity patients in Q3.
The target has been sustained with a significant increase in visits in this category. Volumes for this category of patient acuity has increased by 2356 visits YTD compared to the same quarter last year.

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

Note: The description of this indicator states CTAS 1 and 2 have an 8 hour target, while CTAS 3 has a 6 hour target. Under Pay for Results, this indicator has been changed to 7 hours for non-admitted high acuity. KGH has a target of 7:50 at the 90th percentile based on a ten per cent improvement over last year's baseline. 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:

Work continues to eliminate all delays in the ED visit. Using LEAN principles, we are working to optimize the use of stretchers and chairs in order to increase capacity.
Reducing the time to initial contact with the emergency attending physician and early initiation of tests has been the focus of our Rapid Assessment Zone (RAZ) pilot..

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%

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?**
   85% (44 of 52) of the clinical services are meeting the 90th percentile wait time targets improved from 83% in Q2 and 65% in Q1. Of the 17 supporting indicators in this milestone, 6 are green and 5 are yellow. All yellow indicators are trending favourably.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Focus on waitlist management in the physician offices and Waitlist Committee tracking of all waitlist cases with programs.

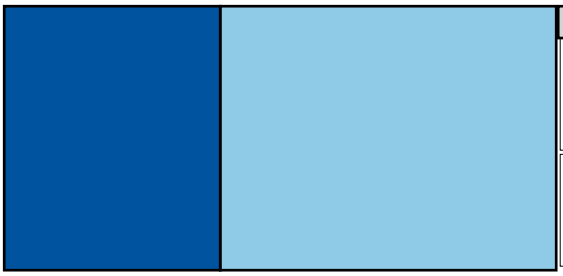
3. **Are we on track to meet the milestone by year end?**
   Favourable trending in all yellow indicators could push this milestone green.

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-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	Y	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	Y	R	R	↓
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	R	R	R	Y	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	G	Y	G	Y	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	G	Y	G	↑
		Cardiac - Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	N/A	↑
		Cardiac - Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	N/A	↑
		Cardiac - Coronary Angioplasty - 90th Percentile Wait Time (Days)	G	G	G	G	N/A	↑
		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)	R	R	R	Y	Y	↑
		Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	R	Y	Y	↑



	12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
Percent of Wait Time Contracted Volumes Achieved	Y	Y	R	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

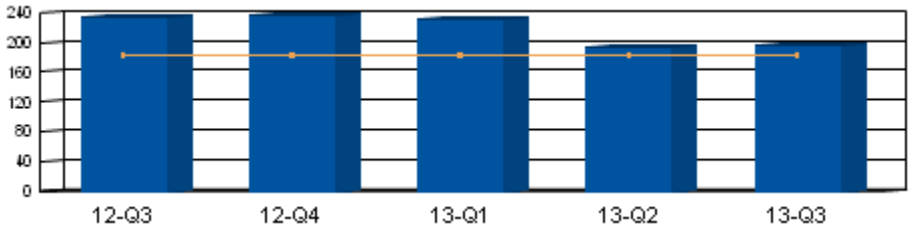
Kingston General Hospital

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-Q3	235	**182**
12-Q4	237	**182**
13-Q1	232	**182**
13-Q2	193	**182**
13-Q3	197	**182**

Interpretation - Patient And Business:

There were 319 cases completed in this quarter with 7 cases having accumulated wait times between 308 to 541 days. The 90 % wait time in days in October was 188 days decreasing to 181 days in December. The median has also trended more positively with 76 days in October transitioning to 48 days in December.

Actions & Monitoring Underway to Improve Performance:

Although OR cancellations for this quarter were 13.8% due to increased organizational patient activity it is anticipated that the additional ortho trauma operative time on weekends will continue to positively influence this indicator. Wait times will continue to be closely monitored at the joint KGH/HDH Wait list committee meetings.

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

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

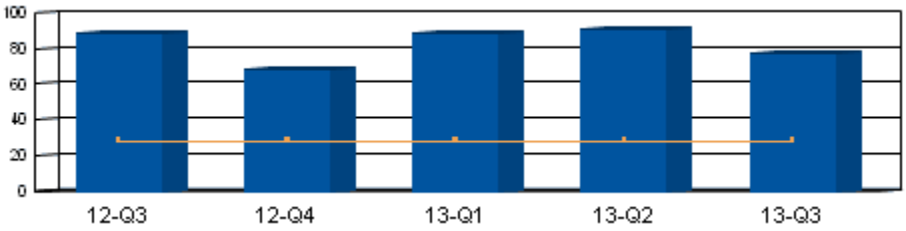
Kingston General Hospital

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-Q3	88	**28**
12-Q4	68	**28**
13-Q1	88	**28**
13-Q2	91	**28**
13-Q3	77	**28**

Interpretation - Patient And Business:

There has been success in decreasing the wait times even though the single magnet is overwhelmed with exam requests. An upcoming staff vacancy may cause an increase in wait times again. Recruitment is occurring.

Provincial target: 28 days
Provincial average: 89 days
KGH average: 93 days
Hamilton Average: 57 days
Ottawa average 291 days
Queensway-Carlton avg.: 153 days
St. Mikes (Toronto): 259 days

Actions & Monitoring Underway to Improve Performance:

Delay in MRI services delays patient care, decision making and can negatively affect LOS. Considerable work has been done to develop a business plan for a second MRI. This will be presented to the hospital and then the LHIN for approval.

Recruiting and maintaining skilled staff is a never ending challenge. KGH requires highly trained staff that are able to work in an environment that has significant stress, as well as patient and physician demands. MRI is in a perpetual "Gridlock" position as there are anywhere from 800-1000 requisition to be booked at any time and every day requires urgent add on cases or time sensitive cases to be completed when the schedule is already flow. The work environment becomes grueling and staff leave for better work life balance opportunities. Getting a second magnet is imperative for staff wellbeing and patient care.

Any delayed access to care is significantly frustrating, stressful and can have a negative effect on the patient's care and health.

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

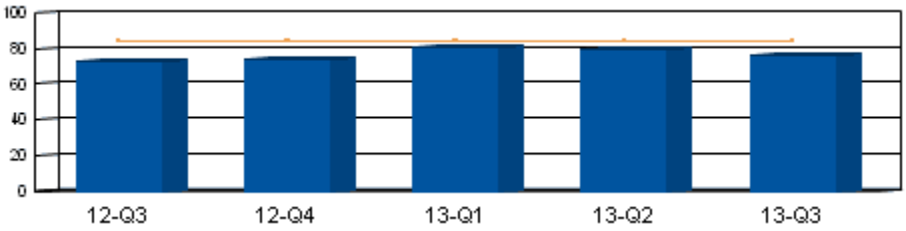
Kingston General Hospital

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



	Actual	Target
12-Q3	73	**84**
12-Q4	74	**84**
13-Q1	81	**84**
13-Q2	79	**84**
13-Q3	76	**84**

Interpretation - Patient And Business:

Based on Q3 results, the ED is not meeting the target wait time for the percent of patients - CTAS 4 and 5 - discharged within 4 hours. Q3 result is trending negatively compared to Q1 and Q2. Inpatient days in ED were up this quarter at 1137 days with November hitting a high of 420 inpatient days for the month which negatively impacts our capacity to see less acute patients.

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. Principles of a rapid assessment zone were trialed in December with some encouraging preliminary results.
The Emergency Department Information System (EDIS) is a valuable tool that allows for continuous monitoring of ED wait times and patient flow 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%

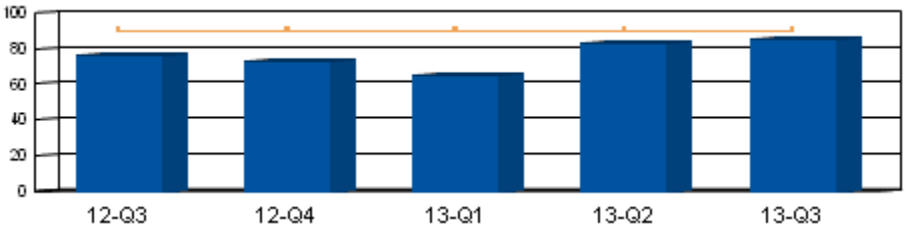
Kingston General Hospital

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-Q3	76	**90**
12-Q4	73	**90**
13-Q1	65	**90**
13-Q2	83	**90**
13-Q3	85	**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.

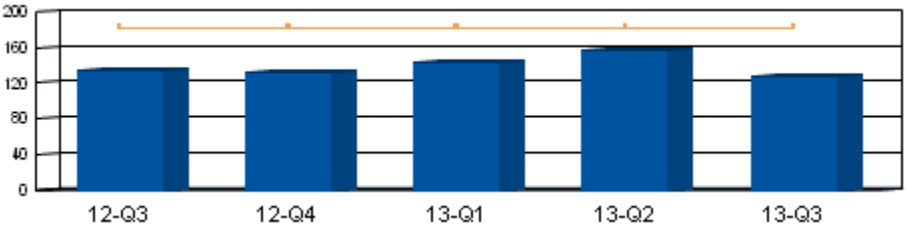
Actions & Monitoring Underway to Improve Performance:

The Q3 results indicate that the target of 90% has still not been reached. Q3 results show that 44 of 52 (85%) of publically reported wait times meet the 90th percentile wait time target. As of Q3, 1 procedure category in General Surgery, 2 in plastic surgery, 1 in Gynecology, 1 in Oral/Dental, 1 in Peds Ortho, 1 Adult Ortho, and the MRI wait time. (Note: there is an assumption that Cardiac wait times are green for Q3). 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-Q3	135	**182**
12-Q4	132	**182**
13-Q1	144	**182**
13-Q2	156	**182**
13-Q3	127	**182**

Interpretation - Patient And Business:

This indicator continues to trend positively well below target.

The median days waiting started at 62 days for the quarter decreasing to 57days in December. The average wait time of 69 days in October also decreased to 65 days in December. Access to additional operating room time on weekends has positively influenced this indicator.

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.

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

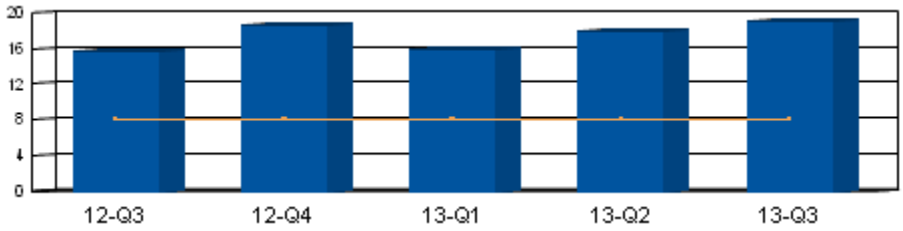
Kingston General Hospital

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-Q3	15.7	**8**
12-Q4	18.7	**8**
13-Q1	15.9	**8**
13-Q2	17.9	**8**
13-Q3	19.0	**8**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for patients admitted with complex conditions is 19 hours. Nine of ten patients are moved to an inpatient bed within 19 hours while 10 percent wait longer than 19 hours. This has been trending negatively since Q1. The Q3 result of 19 hours is 11 hours longer than the 8 hour target.

Actions & Monitoring Underway to Improve Performance:

Ongoing collaboration with program leadership to ensure timely transfer of admitted patients with complex conditions (particularly to Critical Care beds). 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.
Additional 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. 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

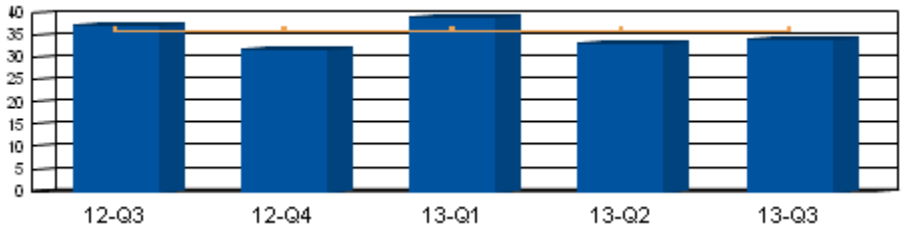
Kingston General Hospital

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-Q3	37	**36**
12-Q4	32	**36**
13-Q1	39	**36**
13-Q2	33	**36**
13-Q3	34	**36**

Interpretation - Patient And Business:

At the end of Q3, 34 percent of patients admitted from the ED were transfered to an inpatent bed within the 8 hour target. As the patient visit volumes increase, the number of admissions also increases.
Emergency Department admitted patient volumes are above target by 278 admissions this quarter and 888 admissions above target YTD. Admitted patient volumes for the ED are up 543 over same time last year. Inpatient bed days are also up over last year with 3050 days YTD compared to 2279 at the same time last year. Inpatient bed days were 1137 in Q3 compared to 942 days in Q3 last year.
Increasing LOS of admitted patients in the ED negatively impacts our capacity to see non-admitted patients in a timely fashion. On average, 19% of all visits to the ED result in admission.

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 the earliest point in the day with a 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.

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%

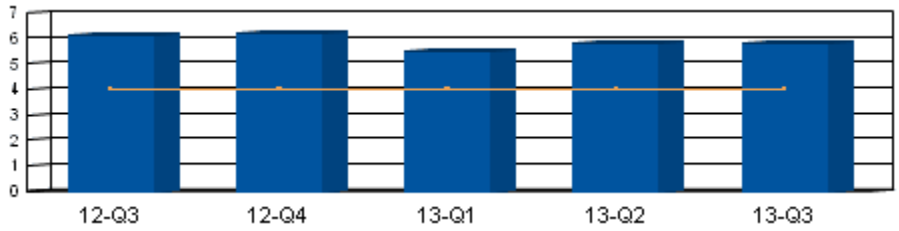
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q3	6.1	**4**
12-Q4	6.2	**4**
13-Q1	5.5	**4**
13-Q2	5.8	**4**
13-Q3	5.8	**4**

Interpretation - Patient And Business:

Based on the Q3 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 5.8 hours. The ability to see patients in this category is dependent on available assessment space. With the increase in admitted patients, increased inpatient bed days and a significant increase in higher acuity patients, these patients tend to wait longer.

Actions & Monitoring Underway to Improve Performance:

A team of ED staff, physicians and Patient Experience Advisors have been working with LEAN principles to eliminate delays in patient flow through the ED. We piloted a Rapid Assessment Zone (RAZ) for 2 days in December and saw encouraging results in reduced wait times for all patients. A second trial is planned for February. The team is also looking at ways to optimize stretcher and chair utilization to increase 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

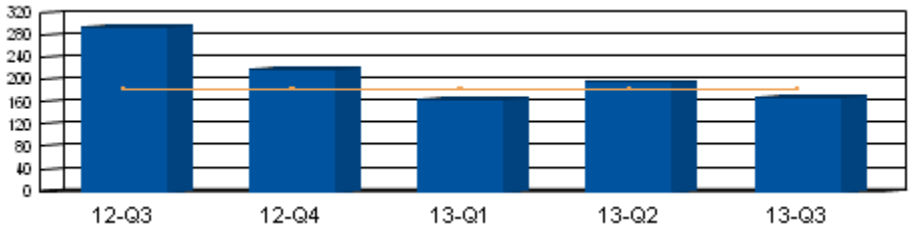
Kingston General Hospital

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-Q3	293	**182**
12-Q4	217	**182**
13-Q1	164	**182**
13-Q2	195	**182**
13-Q3	167	**182**

Interpretation - Patient And Business:

Improved monitoring of office wait times along with access to general emergency OR time has contributed to this positive trending of pediatric surgery. The breakdown of pediatric service activity is as follows:

General Surgery (42 cases):
90% percentile has decreased from 117 days in October to 47 days in December with an average median of 45 days which is an overall improvement of 3 days from last quarter.

Orthopedics (3 cases)
90% percentile was 48 days for this quarter with a median wait of 8 days. Due to the small volumes for this quarter it has small impact on this indicator.

Urology (8 cases)
90% percentile was 130 days this quarter with an average median wait of 73 days. Influencing these days was the completion of 4 cases ranging from wait times of 244 days to 382 days.

ENT (131 cases)
90% percentile for this quarter increased from 183 days in October to 315 days in December with an an average median wait time of 72 days. Two completed cases with wait times between 200-594 days have contributed to the increase from last quarter reporting for this service.

Actions & Monitoring Underway to Improve Performance:

Access to extra available general emergency time to assist with addressing wait times has been encouraged by the program to the service. SPA program leadership continues to monitor the wait times and work with the service.

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

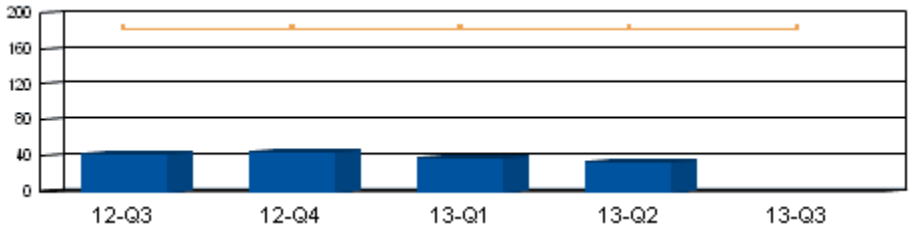
Kingston General Hospital

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)

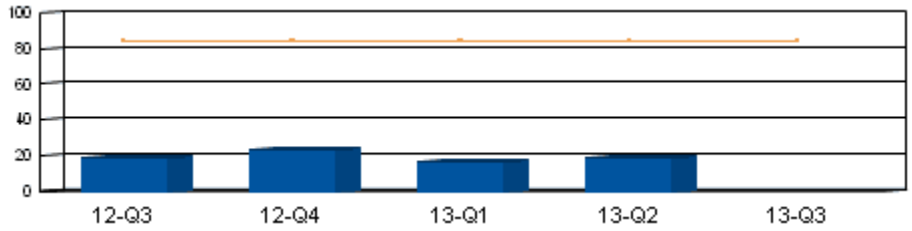


	Actual	Target
12-Q3	43	**182**
12-Q4	45	**182**
13-Q1	37	**182**
13-Q2	33	**182**
13-Q3		**182**

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

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



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

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

Target: Baseline 08/09: 39 days, Target 09/10: 84 days, Target 10/11: 84 days, Target 11/12: 84 days. Target 12/13: 84 Days

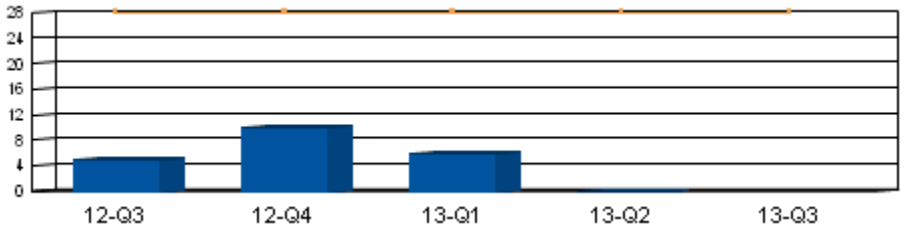
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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

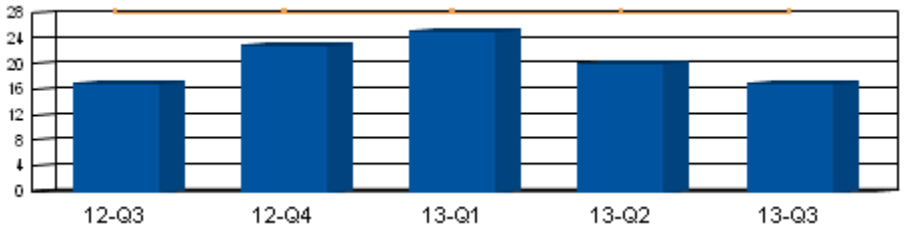


	Actual	Target
12-Q3	5	**28**
12-Q4	10	**28**
13-Q1	6	**28**
13-Q2	0	**28**
13-Q3		**28**

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

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



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

Interpretation - Patient And Business:

Excellent effort to ensure that documentation of patient appointments is correct. i.e. capture not available, timed studies etc. This has significantly dropped doubt wait time. Careful attention to ensuring all priority exams are booked as required within the given time frames.

Actions & Monitoring Underway to Improve Performance:

Supports patient care and flow throughout the continuum of care to ensure there is no delay in service. This helps decrease patient LOS in ER and on the floor.

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

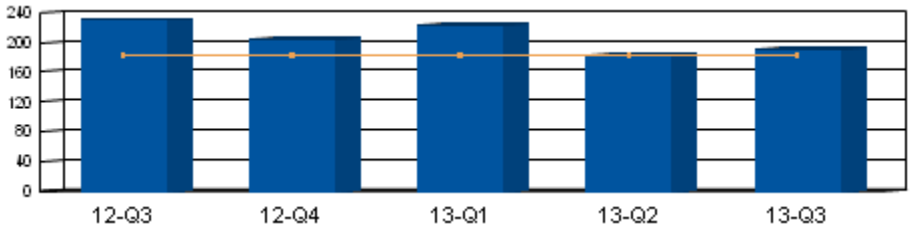
Kingston General Hospital

MS #09

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

Clinical services meet the provincial wait time target

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



	Actual	Target
12-Q3	230	**182**
12-Q4	204	**182**
13-Q1	223	**182**
13-Q2	183	**182**
13-Q3	192	**182**

Interpretation - Patient And Business:

For this quarter the 90% percentile showed improvement with the decrease of 239 days in October to 192 days in December. The median wait time also decreased from 89 days in October to 67 days in December. Influencing this slight increase over the 182 day target was the completion of 7 surgical cases with wait times ranging from 223 - 1696 days on the surgery waiting list.

Actions & Monitoring Underway to Improve Performance:

Continued program support with monitoring office wait lists and continued access to additional OR time during the evening and on weekends should positively contribute to achieving the provincial target of 182 days.

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

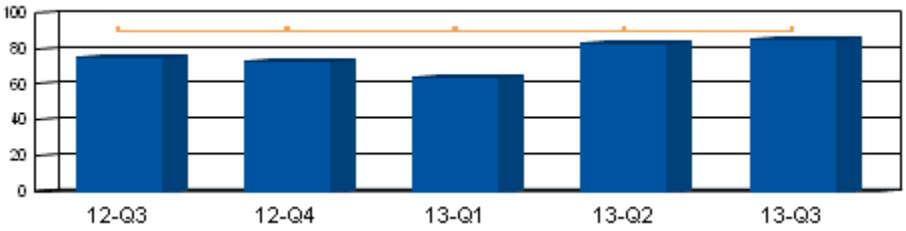
Kingston General Hospital

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-Q3	75	**90**
12-Q4	73	**90**
13-Q1	64	**90**
13-Q2	83	**90**
13-Q3	85	**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 Q3 results indicate that the target of 90% has still not been reached. Q3results show that 40 of 47 (85%) of publically reported surgical wait times meet the 90th percentile wait time target. As of Q3, 1 procedure category in General Surgery, 2 in plastic surgery, 1 in Oral/Dental Surgery,1 in Gynecology, 1 in Peds Ortho and 1 in Adult Ortho. 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. Also it is assumed that specific initiatives within the SPA program targeted at closely monitoring individual wait lists is having a positive impact as well.

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%

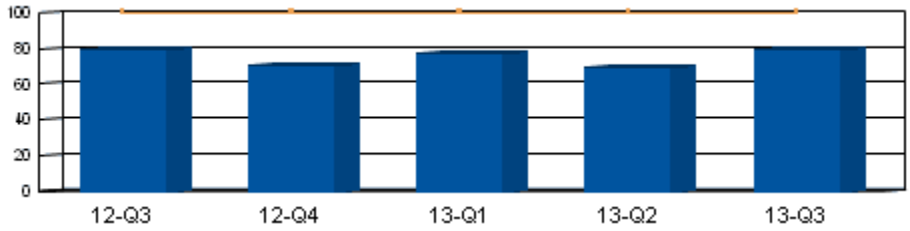
Kingston General Hospital

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-Q3	80	**100**
12-Q4	70	**100**
13-Q1	77	**100**
13-Q2	69	**100**
13-Q3	79	**100**

Interpretation - Patient And Business:

As of Q3 there were 3 incremental volume contracts that were not on target (gallbladders, ventral hernia, ped ACL repair).

Actions & Monitoring Underway to Improve Performance:

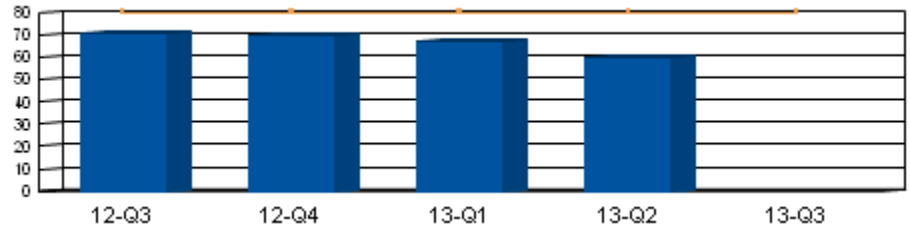
The Wait List Management Committee and the Surgical Program closely monitoring these issues.

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-Q3	70.9	**80**
12-Q4	70.0	**80**
13-Q1	67.0	**80**
13-Q2	59.6	**80**
13-Q3		**80**

Interpretation - Patient And Business:

Q3 data not yet available

Actions & Monitoring Underway to Improve Performance:

Q3 data not yet available

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%

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?** Based upon the Q2 data (Q3 will not be available until mid Feb), the milestone is not met. Of the 4 CCO indicators aligned to this milestone, only 1 is met (radiation consult to start of radiation treatment). Radiation and systemic new case consultations; Systemic treatment wait times and cancer surgery wait times are below target.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** Vacancy in the Medical Oncology human resource plan has been a challenge in part with meeting specific targets, and this is expected to be addressed by Q2 2014. It is understood however a contributing factor is the referral process and the timing of steps for referral (i.e. if referral to oncology is prior to surgery, there will be a predictable and unavoidable breach of a 14 day target between referral and being seen). It is also noteworthy that there is ongoing discussion with CCO about the targets for systemic treatment wait times as the large majority of centres are not meeting targets, and there is difference in opinion about the coding/timing thresholds. Regardless the team is focusing on improvements where possible.

3. **Are we on track to meet the milestone by year end?** No

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** The team is now focused and working very collaboratively to understand and address steps to achieve targets. Chart audits are undertaken on a monthly basis (ie systemic) to evaluate cases exceeding targets; improvement projects have been launched to review and address work flow and data capture issues; redesign of specific referral to consult processes for radiation and systemic , with initial focus on breast cancer populations, is underway; close collaboration between Cancer and SPA programs to have consistent methodology for assignment of priority codes for cancer surgery.

Kingston General Hospital

MS #10

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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 ↓

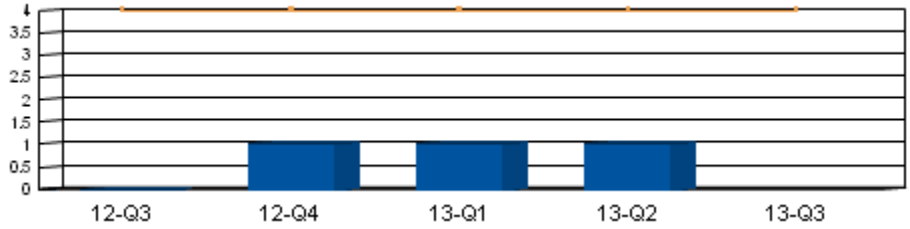
Kingston General Hospital

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-Q3	0	**4**
12-Q4	1	**4**
13-Q1	1	**4**
13-Q2	1	**4**
13-Q3		**4**

Interpretation - Patient And Business:

Q3 data not yet available

Actions & Monitoring Underway to Improve Performance:

Q3 data not yet available

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

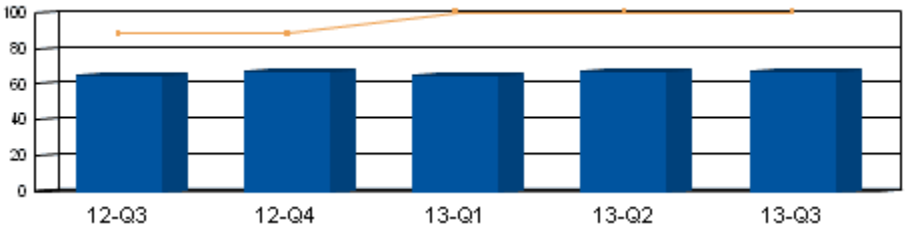
Kingston General Hospital

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

Interpretation - Patient And Business:

KGH is a Cancer Surgery Agreement Hospital with CCO and is accountable for achieving provincially established wait time target by priority category for all cancer surgery it performs. CCO flows incremental cancer surgery funding to KGH annually to support cancer surgery volumes.

As of the end of Q3 F13, KGH is not meeting this target. From a patient perspective patients are waiting longer than the assigned priority wait time target to have their surgery performed at KGH.

From a business perspective, CCO currently does not tie incremental funding to wait time target achievement so the incremental funding is not yet at risk because KGH isn't meeting its' wait time target for cancer surgery. CCO has discussed the possibility of linking funding to wait time achievement. From an internal and external performance reporting perspective, the "red" trend on this indicator may suggest KGH has operational or capacity issues acting as barriers to wait time target achievement.

Actions & Monitoring Underway to Improve Performance:

A Cancer Surgery Wait Time Improvement Team has been established to identify and drive improvements to move to target achievement. Opportunity for improvement exists related to priority coding assigned for specific procedures in various disease sites.

Focused effort will get underway in Q4 to work with the surgeons on the methodology and process for assignment for priority codes. Best practices at other hospitals will also be studied for application to KGH.

Cancer Surgery Wait Time group also reviews all surgical oncology wait lists weekly to identify patients approaching their priority wait time target or who have already breached. These cases are reviewed with the surgeon and if not on hold, every effort is made to get these patients to the OR in the limited extra Oncology OR time available. This process has brought the number of red flagged patients down from 20% to 13%.

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%

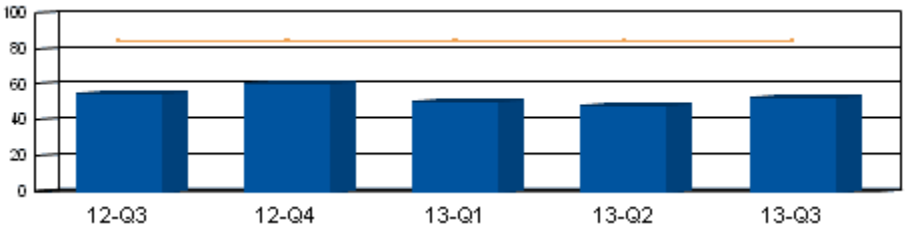
Kingston General Hospital

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-Q3	55	**84**
12-Q4	60	**84**
13-Q1	50	**84**
13-Q2	48	**84**
13-Q3	52	**84**

Interpretation - Patient And Business:

The KGH 90th percentile wait continues to better than the provincial target in days waiting. This is a positive trend as patients are consistently experiencing reasonable waits for cancer surgery. Overall 371 oncology surgical cases were completed this quarter with the 90% percentile trending positively from 54 days in October to 44 days in December.

The following are updates of key procedures:

Urology (81 cases): 90th percentile wait has decreased from 57days in October to 50 days in December. quarter. The median wait also continues to trend positively 20 days in December. Overall the trending continues to be positive and efforts for further improvement are being monitored.

Gynecology (53 cases) - 90th percentile wait in December is 38 days which is down from 77 days in October. The median wait for this quarter continued to trend positively at 25 days this quarter.

Actions & Monitoring Underway to Improve Performance:

The SPA and Oncology program leadership continue to monitor wait times. Services are supported with the continuation of extended operating days and extra booked cases on the general emergency board to manage wait times.

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.

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 remains on hold pending decision regarding change in the IT platform at KGH, and then alignment of resources to support the necessary work.

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?** No, with acceptance of rationale by EMC/Board.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** As before, it is expected that a corporate decision regarding the IT platform will be made by Summer 2013. In the interim, work continues with promotion of interprofessional documentation with a view that documents and/or processes will be 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

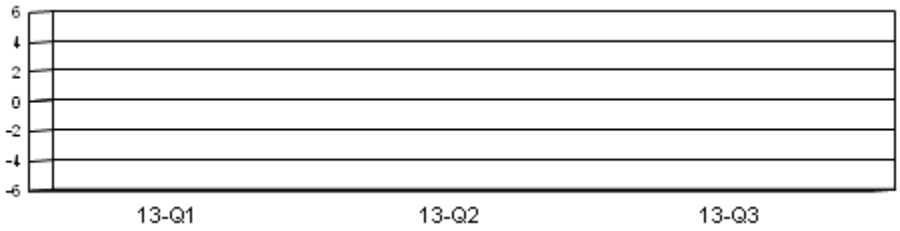
Kingston General Hospital

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		
13-Q3		

Interpretation - Patient And Business:

Project remains on hold pending decision regarding change in IT platform, and then alignment of resources to support the necessary work.

Actions & Monitoring Underway to Improve Performance:

Work continues with the promotion of interprofessional documentation, with a view that documents and/or processes will be automated in the future.

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%

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?** Currently 3 of the 10 competencies outlined in the IPE workplan are met and work is well underway in support of the remaining competencies, and with confidence that a minimum of 6 will be completed by year end. The completed accountabilities are related to development and implementation of learning activities that help enhance practice; support to practice environments that encourage application of knowledge and research; and enabling development of expertise.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The Interprofessional Education (IPE) Steering Committee endorsed the work plan and meets regularly to review progress on the accountabilities. The work plan reflects a focus on IPE for KGH staff this year. The activities associated with each objective are essential first steps to accomplishing the accountability and the plan will evolve over time. The communications team embeds the concept of IPE in communication about events or initiatives linked to interprofessional model of care and patient and family centred care. The collaboration and support of Queen's has also been instrumental.

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?** There is resolve to focus on interprofessional education in KGH at this time particularly in support of staff development, shaping our work environment and supporting a culture of supporting education of the next generation of health care leaders. There is deliberate alignment of the IPE work to that of ICPM and patient- and family-centred care since all are strategically linked in transforming the patient experience. At the corporate level, planning is underway for a patient experience knowledge exchange conference in May 2013 with concurrent sessions related to IPE, ICPM and patient- and family-centred care. As well, increasingly there is opportunity to profile the alignment of these initiatives at conference with the first KGH IPE presentation in British Columbia June 2013.

Kingston General Hospital

MS #12

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	R	Y	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

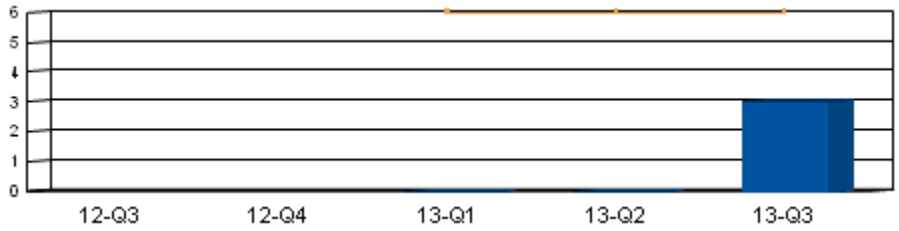
Kingston General Hospital

MS #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-Q3		
12-Q4		
13-Q1	0	**6**
13-Q2	0	**6**
13-Q3	3	**6**

Interpretation - Patient And Business:

The workplan that addresses organizational accountabilities related to educating professional staff is progressing and timelines for Q3 have been achieved. Three of the accountabilities are complete and there is progress on the remaining 7 competencies. The completed accountabilities are related to development and implementation of learning activities that help enhance practice; support to practice environments that encourage application of knowledge and research; and enabling development of expertise. The Interprofessional Education (IPE) Steering Committee endorsed the work plan and meets regularly to review progress on the accountabilities.

Actions & Monitoring Underway to Improve Performance:

KGH is committed to ensuring an interprofessional model of education that will support staff development, shape our work environment and support the education of the next generation of health care leaders. The organizational accountabilities work plan reflects a focus on IPE for staff in this fiscal year. The activities that are associated with each objective are essential first steps to accomplishing the accountability and the work will develop over time. There is deliberate alignment of the IPE work to that of ICPM and patient- and family-centered care since all are strategically linked in transforming the patient experience. At the corporate level, planning is underway for a patient experience knowledge exchange conference in May 2013 with concurrent sessions related to IPE, ICPM and patient- and family-centred care. As well, increasingly there is opportunity to profile the alignment of these initiatives at conference (IPE presentation in BC June 2013).

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

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%	Yellow

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?**

   Planning of and fundraising for the Clinical Investigation Unit continues. Approximately $150k has been identified to cover the costs of detailed drawings and minor modifications to enable use of existing space. Space has been made available for two KinArm robots which are now operational. Several potential donors have been approached and have expressed willingness to consider requests. Fiscal 2012 funding increased by ~$500k marginally exceeding the cumulative target of a 40% increase over baseline, but falling short of an in year goal of an 8% increase.

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

   Accessing the space on Connell 4 for the Clinical Investigation Unit; the space is currently occupied by Medical Genetics and others. Converting Connell 4 into the Clinical Investigation Unit is dependent 100% on the funds raised through UHKF. The in-year increase in external funding was only 2.5%, attributable in part to an ~10% decrease in clinical trials revenue.

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

   Possibly: Full availability of Connell 4, Angada 0, and Connell 2 (*PFT Lab only*) delayed due to delay in clinic moves from FAPC to HDH. Occupancy of space for KGHRI now expected to occur in mid 2013. Fundraising for the Clinical Investigation Unit is off to a promising start.

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

   Ongoing discussion with Queen's RE legal support for clinical trials and full capture of OH and FICR

Kingston General Hospital

MS #13

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	8% Increase of Externally Funded Research Dollars at KGH	G	G	N/A	G	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	G	R	R	Y	↑
		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 ↓

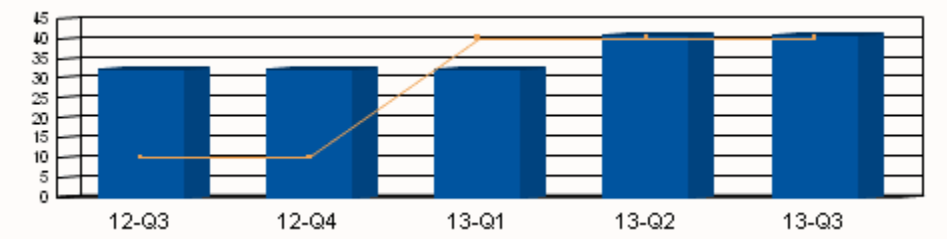
Kingston General Hospital

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

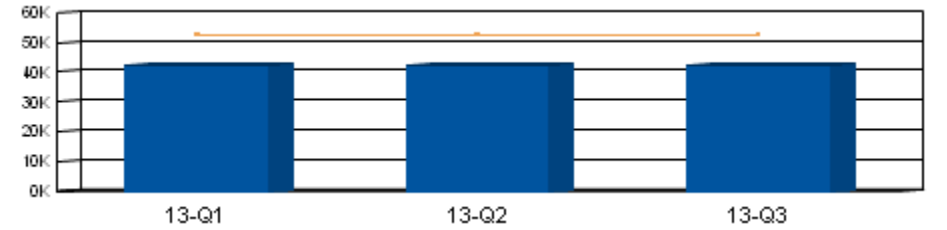
Interpretation - Patient And Business:

KGH Research Annual Report was released in fall 2012 and the data for percent increase in research funds was recorded in Q2. 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	42,000	**52500**
13-Q2	42,000	**52500**
13-Q3	42,000	**52500**

Interpretation - Patient And Business:

Complete turnover of Connell 4 to KGHRI has been delayed as a result of the delay in the clinic moves over to HDH from FAPC. Occupancy now expected to occur in mid 2013. Currently only four 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

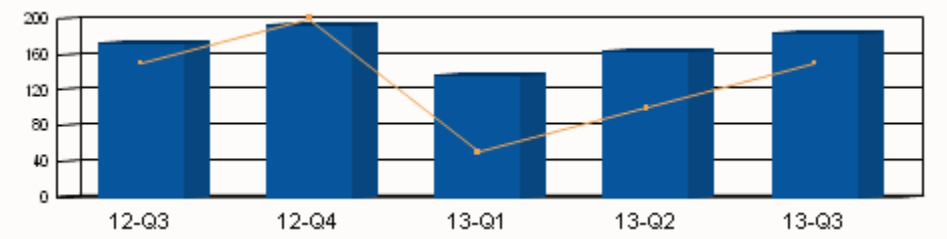
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Active Clinical Trials



	Actual	Target
12-Q3	172	**150**
12-Q4	192	**200**
13-Q1	136	**50**
13-Q2	163	**100**
13-Q3	184	**150**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q3.

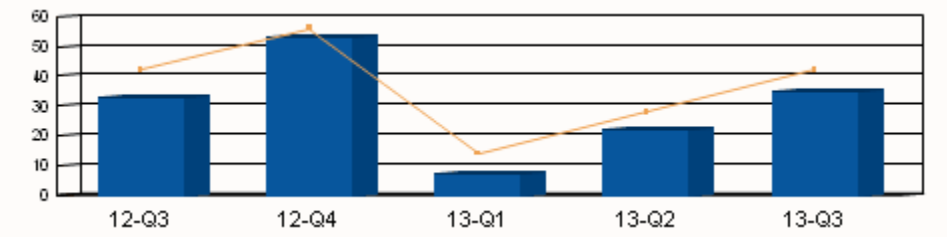
Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the third quarter (Q3).

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-Q3	33	**42**
12-Q4	53	**56**
13-Q1	7	**14**
13-Q2	22	**28**
13-Q3	35	**42**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q3.

Business Perspective: Based on the fiscal year to date, KGH is slightly behind target by the end of the third quarter (Q3). 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.

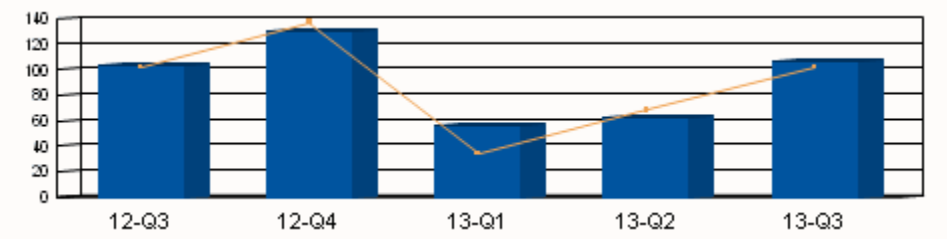
Kingston General Hospital

MS #13

Cultivate patient oriented research

Clinical research space at KGH increases by 25%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
12-Q3	103	**102**
12-Q4	131	**137**
13-Q1	56	**34**
13-Q2	63	**68**
13-Q3	107	**102**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q3.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the third quarter (Q3).

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.

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.

Kingston General Hospital

MS #14

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3
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

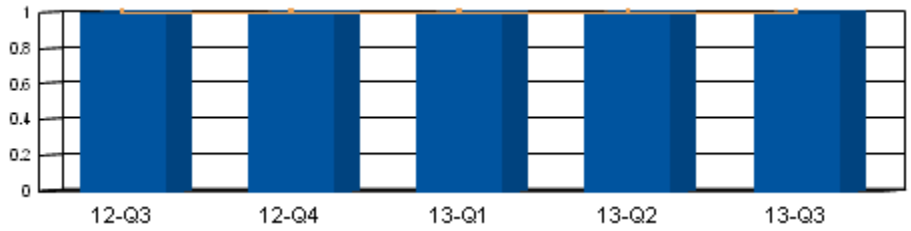
Kingston General Hospital

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-Q3	1	**1**
12-Q4	1	**1**
13-Q1	1	**1**
13-Q2	1	**1**
13-Q3	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)

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 but 2 target service volumes (N=18)) are green except Chronic Kidney Disease Program (weighted units) and Cardiac bypass surgery volumes. CKD is above targeted volumes and waiting list for cardiac bypass is low. It is worth noting that the corridors of performance for our key volume indicators recognize when volumes exceed certain limits and can therefore turn red as a result of too much activity.

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-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
Increase our focus on complex-acute and specialty care	Target service volumes are met	Percent of Contracted Volumes Achieved	G	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	Y	↓
		Chronic Kidney Disease Program - (Weighted Units)	Y	G	G	Y	Y	↓
		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		MRI Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	↑
		Emergency Department Non-Admitted 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-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
Primary Hip & Knee Replacement Volume (Quality Based Procedure (QBP))	N/A	N/A	Y	G	G	↑
Kidney Transplants	R	G	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 ↓

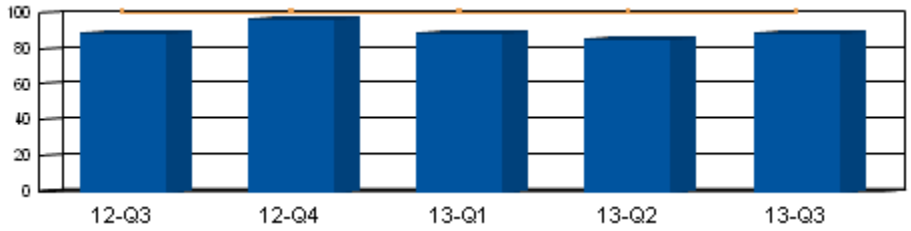
Kingston General Hospital

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

Interpretation - Patient And Business:

As of Q3, 25 of 28 contracted volumes were on target. The 3 that were not are wait time contracted volumes in surgery and have been highlighted under the wait time contracted volume indicator (gallbaldder, ventral hernia, ped ACL repair)

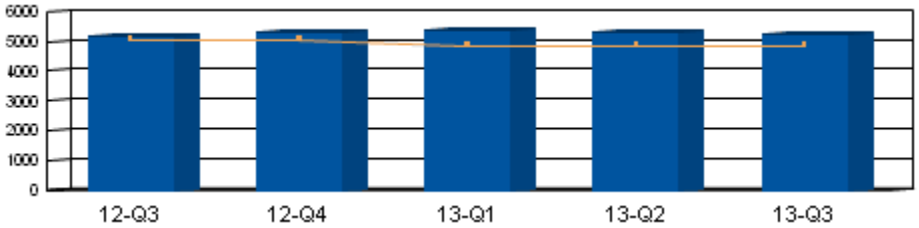
Actions & Monitoring Underway to Improve Performance:

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-Q3	5,204	**5055**
12-Q4	5,332	**5058**
13-Q1	5,383	**4850**
13-Q2	5,284	**4850**
13-Q3	5,256	**4850**

Interpretation - Patient And Business:

This indicator 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

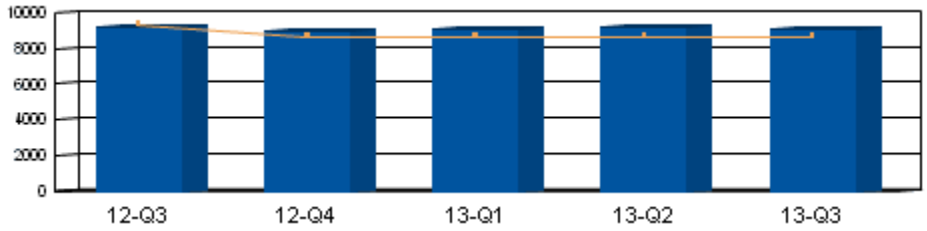
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Total Inpatient Weighted Cases



	Actual	Target
12-Q3	9,207	**9326**
12-Q4	8,959	**8654**
13-Q1	9,060	**8654**
13-Q2	9,172	**8654**
13-Q3	9,080	**8654**

Interpretation - Patient And Business:

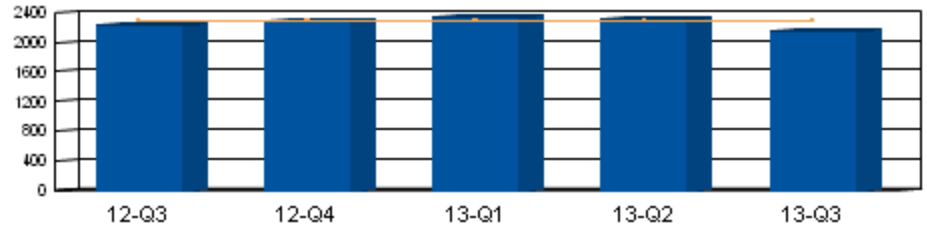
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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-Q3	2,234	**2286**
12-Q4	2,290	**2286**
13-Q1	2,331	**2286**
13-Q2	2,311	**2286**
13-Q3	2,159	**2286**

Interpretation - Patient And Business:

The ability to meet case volumes continues to be a challenge as a result of the number of gridlock days called this quarter in response to increased organizational patient activity and reduced access to inpatient resources for elective surgery activity. This challenge is also reflected in the OR cancellation rate which is 13.8 % for Q3, a substantial increase from Q1 - 8.4%.

Actions & Monitoring Underway to Improve Performance:

Inpatient and outpatient OR case volume activity is monitored by OR management and the Surgical Preoperative Anesthesia (SPA).

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

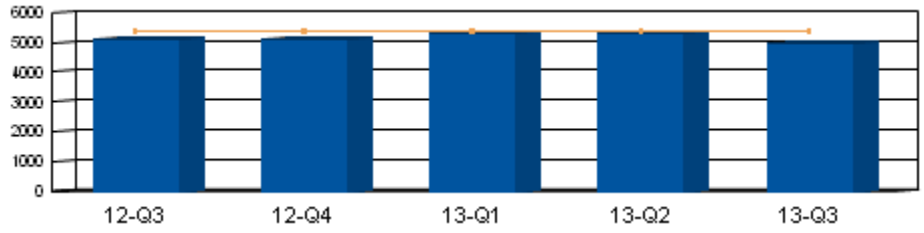
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
12-Q3	5,104	**5345**
12-Q4	5,088	**5345**
13-Q1	5,294	**5345**
13-Q2	5,332	**5345**
13-Q3	5,004	**5345**

Interpretation - Patient And Business:

The number of gridlock days called this quarter in response to increased organizational patient activity and reduced access to inpatient resources for elective surgery activity is reflected in this quarter with an OR cancellation rate of 13.8 % which is a substantial increase from 8.4% in the first quarter of this year.

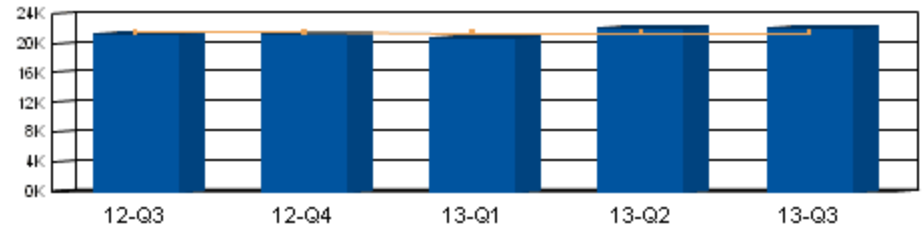
Actions & Monitoring Underway to Improve Performance:

Program leadership continues to monitor patient flow and utilize any additional strategies such as temporary Recovery Room overnight stays to ensure that OR cancellation 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-Q3	21,184	**21400**
12-Q4	21,194	**21400**
13-Q1	20,796	**21323**
13-Q2	22,085	**21323**
13-Q3	22,068	**21323**

Interpretation - Patient And Business:

Ambulatory target volumes in Q4 will be reflective of the transfer of clinics/patient activity to the Hotel Dieu commencing February 18th, 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

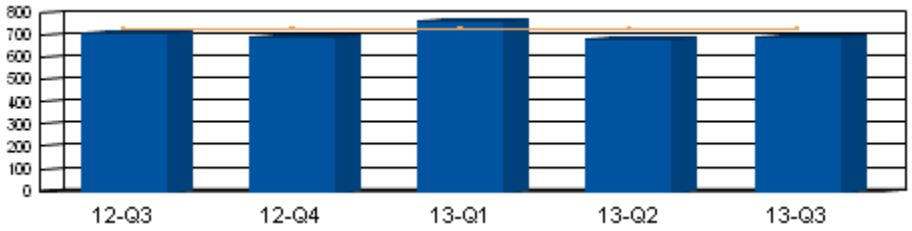
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Angiography Volumes



	Actual	Target
12-Q3	705	**725**
12-Q4	686	**725**
13-Q1	759	**725**
13-Q2	677	**725**
13-Q3	689	**725**

Interpretation - Patient And Business:

Cardiac Angiography volumes are being met. Funded base is 2900 (shown as target) which is adequate to meet the patient demand within the region.Procedures are being done well within the recommended wait times for all angiography.

Actions & Monitoring Underway to Improve Performance:

Funded base volume is 2900 (target), however, this year (12/13) we were given an additional base of 220 procedures and a one time increase of 73 procedures for a total of 293 new additional funded cases. This new total of 3193 funded cardiac angiographies likely exceeds the demand for patients in this region which puts us at risk for recovery of funds related to this line.

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

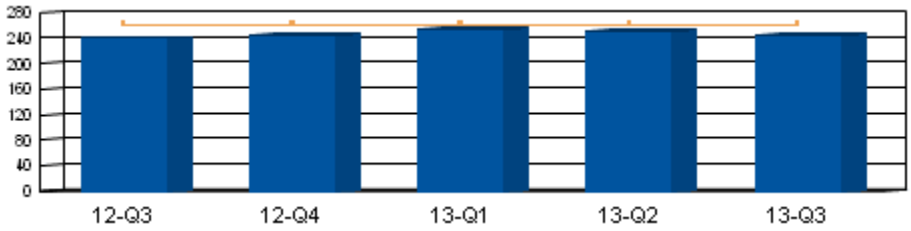
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
12-Q3	240	**262**
12-Q4	245	**262**
13-Q1	254	**262**
13-Q2	252	**262**
13-Q3	246	**262**

Interpretation - Patient And Business:

Cardiac Angioplasty volumes are being met. No concerns as funded base volumes are adequate to meet the needs of patients in the region. Procedures are being done well within the recommended wait times for all angioplasties with virtually no wait list. Most angioplasties are completed as part of the diagnostic catheterization (angiography) procedure. This is referred to as same sitting PCI (percutaneous intervention) or ad hoc. This means that the patient has only one procedure for both the diagnostic and intervention components when appropriate.

Actions & Monitoring Underway to Improve Performance:

KHG is on track to meet funded volumes for this year. Demand has remained steady and is 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.Funded base volume is 1050. This year (12/13), an additional 18 procedures were added to base and another 6 procedures added as a one-time increase. This year's total funded activity is 1074 angioplasties which is more volumes than is required to meet the needs of the patients in this region. This may result in a recovery of funding related to this line.

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

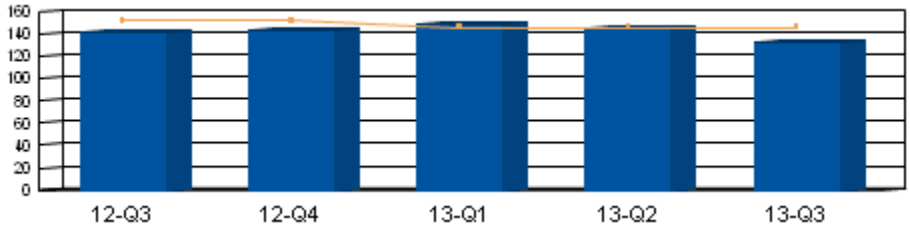
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Cardiac - Bypass Volumes



	Actual	Target
12-Q3	141	**152**
12-Q4	143	**152**
13-Q1	148	**146**
13-Q2	146	**146**
13-Q3	132	**146**

Interpretation - Patient And Business:

Cardiac surgery volumes are slightly behind target volumes at the end of Q3 due to a short waiting list, patients delaying surgery by choice or they required additional testing and then repeat clinic appointments prior to surgery. Maximum recommended wait times for elective and semi-urgent bypass surgeries are being met 100% of the time. Volumes have remained constant over the past 3 years.

Actions & Monitoring Underway to Improve Performance:

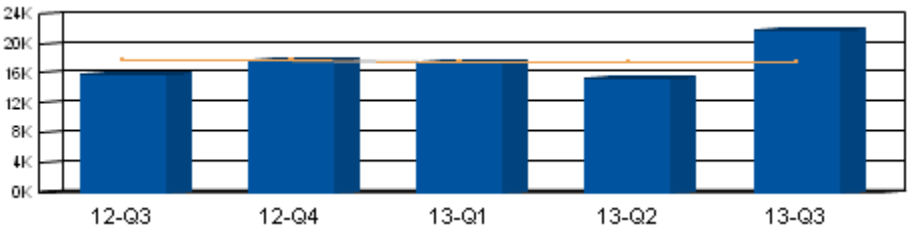
Funding for cardiac surgeries is at risk of being recovered if target volumes are not met. Patient need is being met, therefore, target maybe greater than demand. Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Program and the Wait Times Committee. Surgical volumes and 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.

Transaortic Valve Implantation (TAVI) procedures will be captured as cardiac surgery. Anticipated start date is January 2013.

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-Q3	15,792	**17707**
12-Q4	17,638	**17707**
13-Q1	17,336	**17498**
13-Q2	15,171	**17498**
13-Q3	21,763	**17498**

Interpretation - Patient And Business:

This activity area covers a range of clinical activities with the renal service.

This is activity is driven by clinical need of the patient population. Whilst the overall population with CKD remains relatively stable the clinical acuity of patients has seen greater activity in the Q3 period.

Actions & Monitoring Underway to Improve Performance:

Most of the increasing activity is seen in the main Renal Unit (burr 3). Patients with greater clinical instabilities having treatment throughout the programs seven locations will 'fall-back' to the KGH site when clinically necessary.

The main concern with this pattern is the continuing capacity (human and physical) to support patient's clinical needs.

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

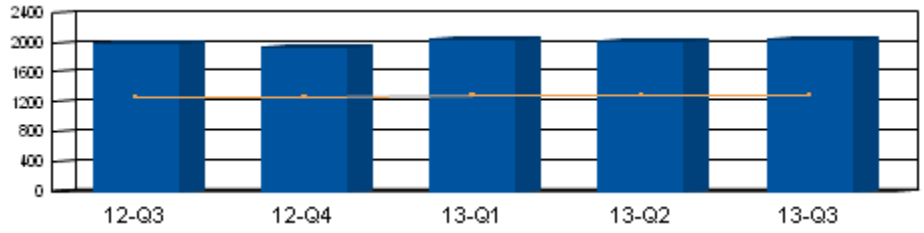
Kingston General Hospital

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-Q3	1,979	**1263**
12-Q4	1,929	**1263**
13-Q1	2,032	**1286**
13-Q2	2,026	**1286**
13-Q3	2,033	**1286**

Interpretation - Patient And Business:

Target hours exceeded as per usual operational structure of running 2 CT's in order to meet the needs of the organization.

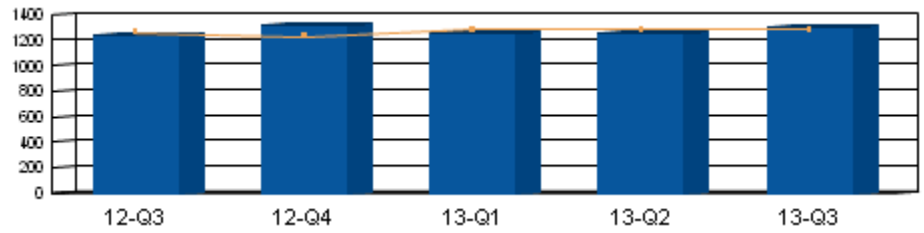
Actions & Monitoring Underway to Improve Performance:

Will continue to manage budget in order to maintain workload and patient demands

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-Q3	1,239	**1259**
12-Q4	1,322	**1228**
13-Q1	1,262	**1283**
13-Q2	1,250	**1283**
13-Q3	1,298	**1283**

Interpretation - Patient And Business:

We have been able to meet the hours even with the additional incremental volume. An upcoming staff vacancy starting mid-February will have a negative impact to this though. We are in recruitment mode for another staff member.

Actions & Monitoring Underway to Improve Performance:

Having adequate staffing is critical to maintaining hours. Staff vacancies, maternity leaves etc have been an ongoing challenge for years.

One highly motivated and skilled GenRad technologist is taking the MRI course and will be available in the spring of 2014. However there is a need to recruit another MRI technologist immediately.

Decreased staffing means there will be decreased operational hours, increased wait times and increased staff stress and challenges for the remaining staff.

Patient exams will be delayed which delays treatment decisions.

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.

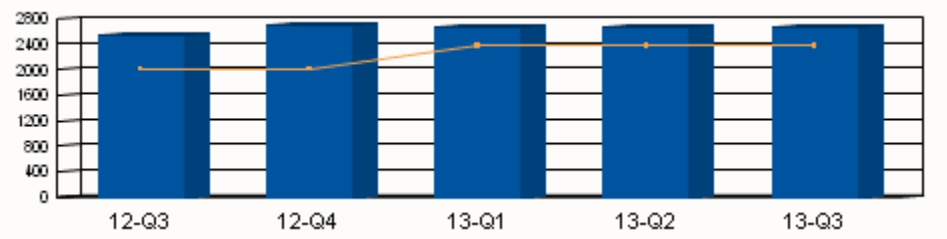
Kingston General Hospital

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-Q3	2,555	**2002**
12-Q4	2,713	**2002**
13-Q1	2,658	**2370**
13-Q2	2,683	**2370**
13-Q3	2,657	**2370**

Interpretation - Patient And Business:

Emergency Department admitted patient volumes are above target by 278 admissions this quarter and 888 admissions above target YTD. Admitted patient volumes for the ED are up 543 over same time last year.
Inpatient bed days are also up over last year with 3050 days YTD compared to 2279 at the same time last year. Inpatient bed days were 1137 in Q3 this fiscal compared to 942 days in Q3 last year.
Increasing LOS of admitted patients in the ED negatively impacts on our capacity to see non-admitted patients in a timely fashion. On average, 19% of all visits to the ED result in admission.

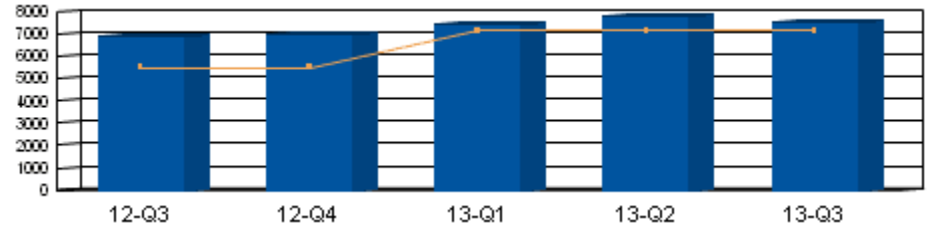
Actions & Monitoring Underway to Improve Performance:

The demand for inpatient beds is greater than bed capacity. All programs are working with partners at other organizations and within the community to find alternatives to ED visits and hospital admissions.

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-Q3	6,867	**5481**
12-Q4	7,033	**5481**
13-Q1	7,423	**7149**
13-Q2	7,766	**7149**
13-Q3	7,575	**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

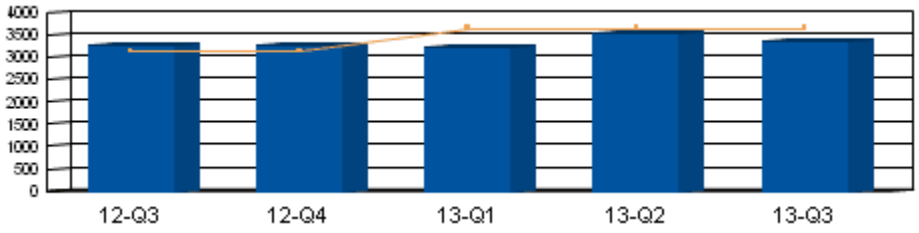
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

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



	Actual	Target
12-Q3	3,250	**3138**
12-Q4	3,284	**3138**
13-Q1	3,242	**3647**
13-Q2	3,547	**3647**
13-Q3	3,349	**3647**

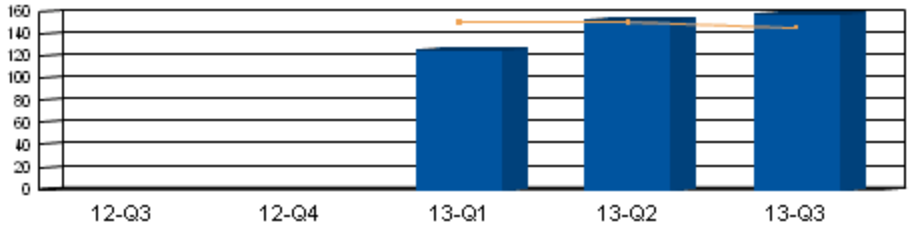
Interpretation - Patient And Business:

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

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



	Actual	Target
12-Q3		
12-Q4		
13-Q1	126	**150**
13-Q2	152	**150**
13-Q3	158	**145**

Interpretation - Patient And Business:

A new volume target was introduced in this quarter by the SELHIN. This resulted in a reduction of the overall volumes of 18 cases. The new 2012-2013 target for primary unilateral hips is 230 and for the primary unilateral knees is 351cases. All efforts to meet these targets are being implemented by the program although challenges continue to exist with a 13.8% cancellation rate due to increased unpredictable patient activity across the organization.

Actions & Monitoring Underway to Improve Performance:

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

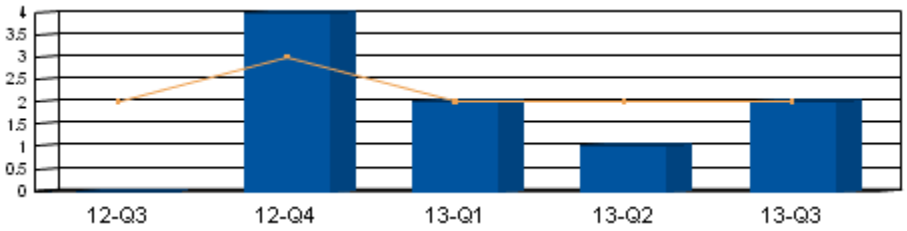
Kingston General Hospital

MS #15

Increase our focus on complex-acute and specialty care

Target service volumes are met

Indicator: Kidney Transplants



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

Interpretation - Patient And Business:

Kidney transplant numbers are driven most significantly by the availability of organs donated through deceased patients.

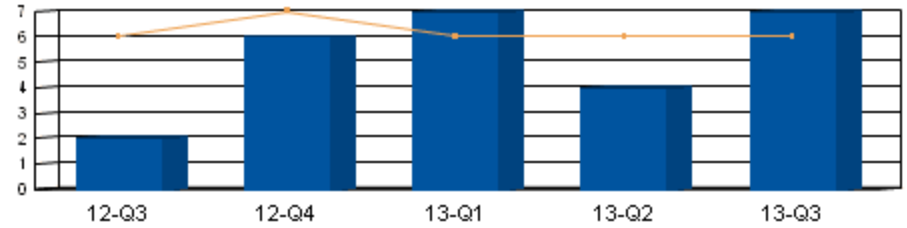
Actions & Monitoring Underway to Improve Performance:

We have been able to respond appropriately to organ availablity and support the transplantation for patients in our local region.

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

Indicator: Stem Cell Transplants



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

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

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

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

Target: Baseline 08/09: 8 , Target 09/10: 44, Target 10/11: 44, Target 11/12: 25, 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-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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)	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 ↓

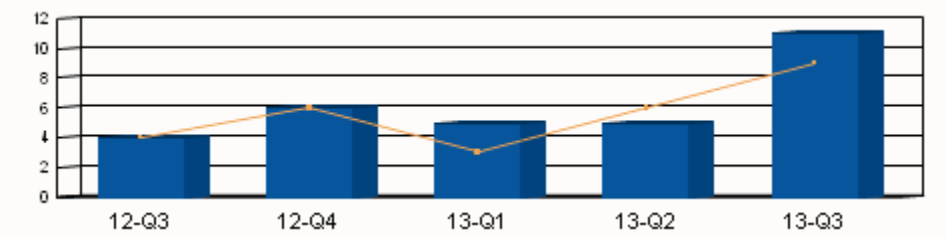
Kingston General Hospital

MS #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-Q3	4	**4**
12-Q4	6	**6**
13-Q1	5	**3**
13-Q2	5	**6**
13-Q3	11	**9**

Interpretation - Patient And Business:

A very successful uptake by programs to implement OS.

Actions & Monitoring Underway to Improve Performance:

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

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?**
   Launch of the scheduling project is green and will continue on a green trend in Q4. Sick time has increased to 11.02 from below 11 average sick days in Q2. Overtime has decreased from Q2

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Concerns regarding the capacity of the organization to complete surveys this winter necessitated the decision to postpone the Workplace Pulse Survey. A critical element was the plan to kick off the KGH Engagement Initiative, which includes engagement surveys, engagement action planning, and associated training for leaders in the spring. Research has proven that engagement ratings have a direct impact with staff satisfaction, reduction of sick time, increased quality/productivity and safety in the workplace. Related to sick time, there also has been an increase in infectious illnesses in Q3, and a community outbreak of influenza in Kingston. We continue with a number of critical care vacancies.

3. **Are we on track to meet the milestone by year end?**
   No, we will not be conducting the survey to measure this percentage increase. Additionally, we do not foresee meeting the 10.5 average sick day target for this fiscal year, however, through a continued focus on wellness and attendance promotion we anticipate that we will drop under 11 average sick days for Q4.

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

   Activities continue on a number of activities that will increase staff satisfaction. These include redesign of the recruitment function and selection of an applicant tracking system to improve the time to hire and fill vacancies. The launch of the manager onboarding system will refresh all leaders with basic knowledge and skills. Continued action on the Workplace Pulse Survey focus group information such as the upgrade for the Safe Reporting System and expanding hours for hot food and coffee on nights. Grants received to improve intercultural competency at work, and "Vitality at Work".

Kingston General Hospital

MS #17

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	R	N/A	N/A	N/A	
		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↑
		Launch the Staff Scheduling Project	N/A	G	N/A	G	G	↑
		Percent of Overtime Hours	Y	Y	Y	Y	Y	↓
		Percent Sick Time Hours	Y	Y	Y	Y	R	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

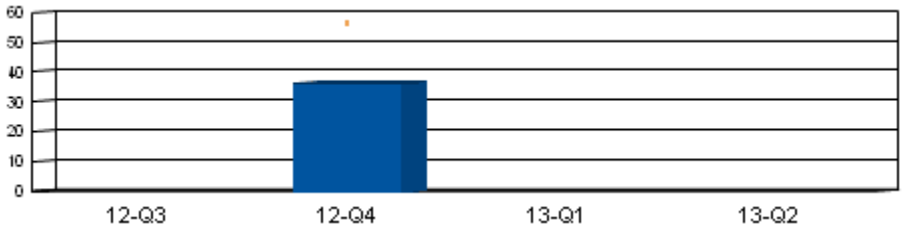
Kingston General Hospital

MS #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-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 communication plan approved and survey conducted end of February

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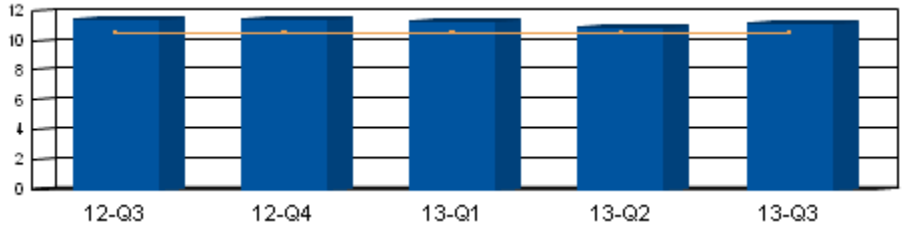
Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
12-Q3	11.4	10.5
12-Q4	11.4	10.5
13-Q1	11.3	10.5
13-Q2	10.9	10.5
13-Q3	11.1	10.5

Interpretation - Patient And Business:

The rolling average for the end of the third quarter was 11.02. This is not at target levels, however the number of incidents remains stable and the overall average is lower than at Q3 one year ago.

Actions & Monitoring Underway to Improve Performance:

Some increases in sick time during the fall and winter period are expected, however, there has been a noticeable increase in infectious-type illness in the last quarter. Outbreaks of influenza were reported in the community and a marked increase in hospital. Two grants were applied for and awarded under the healthy work environments (HWE) program with the focus on health and wellness. Specifically, mental health will be a focus given 1 in 5 of our sick claims are related to mental health issues.

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

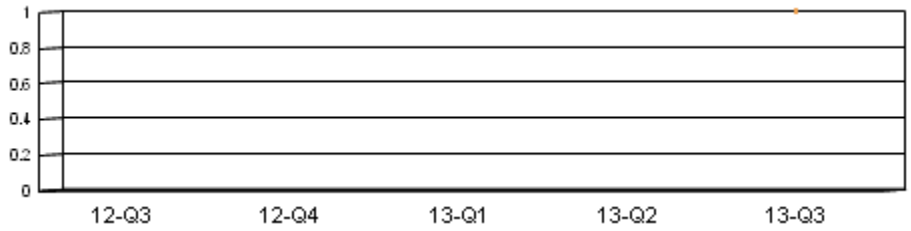
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Launch the Staff Scheduling Project



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

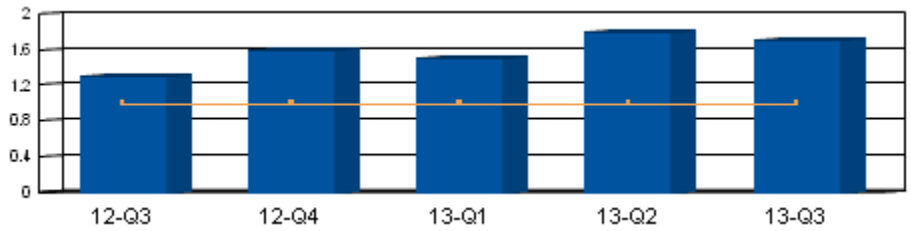
Interpretation - Patient And Business:

Staff Scheduling project is on target

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-Q3	1.3	**0.99**
12-Q4	1.6	**0.99**
13-Q1	1.5	**0.99**
13-Q2	1.8	**0.99**
13-Q3	1.7	**0.99**

Interpretation - Patient And Business:

Overtime is also posting a negative variance with Pediatrics, Critical Care, Emergency, SPA and Medicine programs with the highest variances year to date.

Actions & Monitoring Underway to Improve Performance:

Staffing levels and occupancy levels influenced overtime more than levels of staff absences, however, should the former improve, it would be anticipated that sick time in those areas would also make some improvements. The launch of the scheduling and time capture project may also impact on appropriate staffing levels as master rotations are being reviewed.

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%

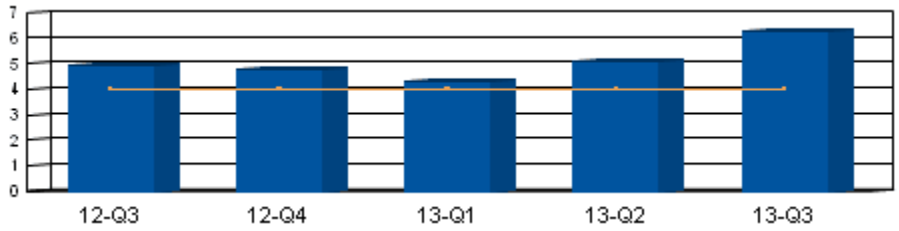
Kingston General Hospital

MS #17

People

Overall staff satisfaction ratings improve by 20%

Indicator: Percent Sick Time Hours



	Actual	Target
12-Q3	4.9	**4**
12-Q4	4.8	**4**
13-Q1	4.3	**4**
13-Q2	5.1	**4**
13-Q3	6.3	**4**

Interpretation - Patient And Business:

Sick hours and dollars are in a negative variance position year to date. December variances were led by Critical Care, Pediatrics, Oncology and Surgical Programs. There has been an noticeable increase in infectious-type illness in the last quarter. Outbreaks of influenza were reported in the community and a marked increase in hospital.

Actions & Monitoring Underway to Improve Performance:

Several staff who had an exposure or may become exposed were given Tamiflu and/or a flu vaccine in December, much later than what would have been the desired time frame. Reported uptake on the flu vaccine remained in the typical 40-45% range. Mental health will be a focus in Q4 given 1 in 5 of our sick claims are related to mental health issues.

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%

Health and Safety Scorecard targets are met

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

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?**

   Thirteen (13) measures are on target however the performance has declined related to receipt of Ministry of Labour Orders, the number of Lost Time Injury days and WSIB Healthcare claims in Q3. There continues to be improvement related to Fit Testing and Training completion, needlestick injuries. The MSI lost time injuries remains below the target and the WSIB NEER performance index resulted in a $300,000 rebate.

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

   There was a 50% increase in the number of days lost due to workplace injury/illness – this was in relation to two Lost Time Injuries that resulted in significant time off – one being a head injury and the other a high risk needlestick injury. Top causes of WSIB Healthcare claims were falls (6), MSI other (4) and physical violence (3). Ministry of Labour Orders were issued on the Hydroclave in Environmental Services and negative pressure rooms

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

   We may still be able to meet the target again for Q4 (it had been met in Q1).

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

   Focus in Q4 on supervisor roles & responsibilities with regard to hazard recognition and control. Creation of a Wellness Centre in the new year, development of online training related to needlestick usage, the purchase of new ergonomic chairs and small equipment and continued follow-up to support leaders with investigations and reduction of hazards in the workplace. Follow-up on all outstanding items from Ministry of Labour Orders and Executives and Directors provided with new reports on safety activities/issues in their portfolios.

Kingston General Hospital

MS #18

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

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

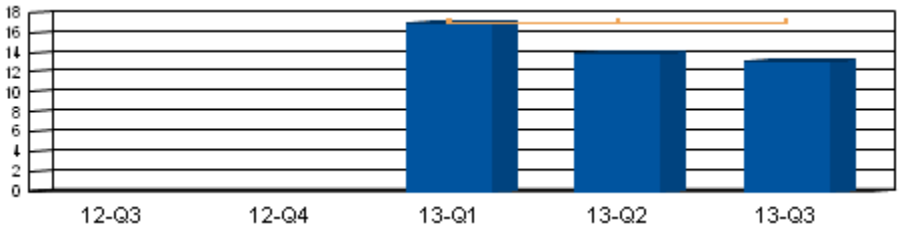
Kingston General Hospital

MS #18

People

Health and Safety Scorecard targets are met

Indicator: Number of Health & Safety Scorecard Target Indicators Met



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

Interpretation - Patient And Business:

13 measures on target (4 yellow, 9 green); during Q3 respirator fit testing compliance improved however results on MOL orders and number of LTI days declined. MOL orders were issued on the Hydroclave in Envir. Services and negative pressure isolation rooms. There was a 50% increase in number of days lost due to workplace injury/illness- this was in relation to 2 LTIs that resulted in significant time off work- one being a head injury and other a high risk needlestick.

Actions & Monitoring Underway to Improve Performance:

Focus on Q4 will be on supervisor roles and responsibilities in the prevention of workplace illness/injury including hazard recognition (workplace inspections) and control (implementation of corrective measures/safety improvements).

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

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?**
   We did not launch the engagement initiative in Q3 due to capacity of organization and resources. Percent of staff that complete mandatory online training remains steady at 94%.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   Review of competing priorities, monies and resources postponed the date to launch the engagement initiatives and conduct engagement surveys until spring 2013.

3. **Are we on track to meet the milestone by year end?**
   We are not on track to meet the engagement metric for Q4 for action plans to be in place, however, a number of “engagement” activities initiatives have been underway.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Payment for usage of OHA engagement surveys; contracted resource to manage the process; agreement to proceed on leading for engagement and material to be purchased in Q4 for roll-out in Q1. Continue to monitor mandatory training completion rates and perhaps add to Performance Agreements for all employees. Design of an interactive online learning center calendar and enabling remote access. Leverage of the Learning Management System to provide online learning courses (350) integrated to the leadership competencies. Redesign of orientation for April 2013. Completed roll-out of employee kiosks (My KGH) to access email, KGH Today and postings. Launch of the patient experience advisor led staff sessions which enables staff to hear from patients about their treatment experience in their unit, and identify opportunities for improvement and sustainment of what is working well. A number of front-line staff have and will be trained in continuous improvement and participate in improvement teams. Launch of our first “KGH Community Celebration” week in January.

Kingston General Hospital

MS #19

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3
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	R	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

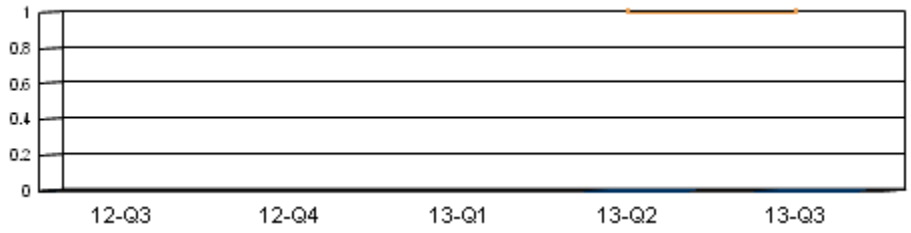
Kingston General Hospital

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-Q3		
12-Q4		
13-Q1		
13-Q2	0	1
13-Q3	0	1

Interpretation - Patient And Business:

This activity will follow the engagement action plan which begins with the survey in April 2013. We expect to have EA Plans in place following survey debriefing and Leader training late Q2 and early Q3.

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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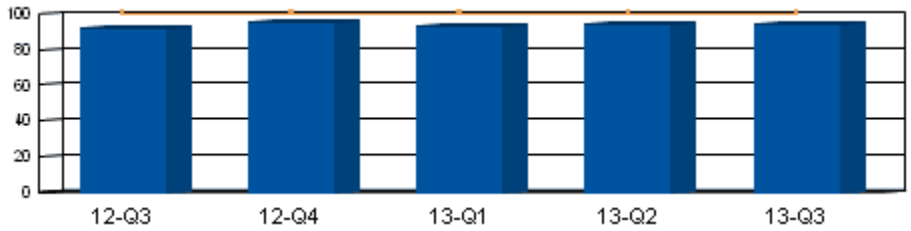
Indicator: Percent of Staff that Complete Mandatory Online Training Programs



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

Interpretation - Patient And Business:

93.6 % of mandatory training complete down from 93.8 last quarter. Monthly updates and reminders continue to be sent. Scores for course completion rates are:
Accessibility: 97.9
Workplace Violence : 97.3
MSI Non clinical : 91.2
WHIMMIS: 91.0
MSI Clinical : 89.2

Actions & Monitoring Underway to Improve Performance:

Continue to monitor completion rates and send out emails to Leaders directly responsible for staff who have not completed mandatory training. Continued emphasis on the importance and legal requirement for mandatory training completion. Direct leaders should consider direct report completion rates as an element of their annual performance assessments for April 1, 2013

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

Target: Target 11/12: 100%, 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?**
   As of Q3, 97 leaders had completed their continuous improvement training. This has exceeded the original target of 90. In fact, an additional 51 strategic project team members (automatic drug cabinets, scheduling projects), doctors, residents, nurses, clinical educators, nurse practitioners, charge nurses, pharmacists, pca's have been trained who were not included in the target of 90.

2. **What are the contributing factors to the current performance of the indicators for this milestone?**
   The support of the Process Excellence Team and coordination/facilitation by the new Director, Quality, Patient Safety and Risk Management.

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

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**
   Follow-up to ensure that all leaders who have received training, also complete one improvement cycle using a PSDA and participating in a value stream mapping exercise.

Kingston General Hospital

MS #20

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

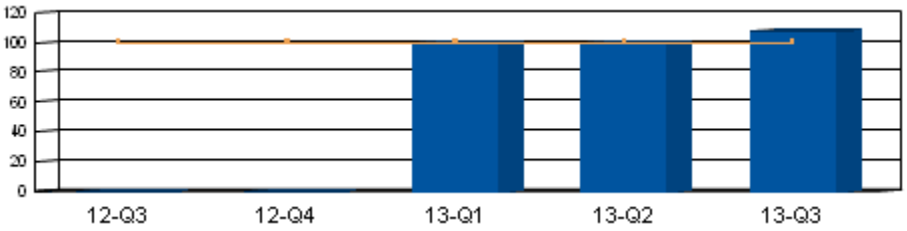
Kingston General Hospital

MS #20

Processes

100% of KGH managers complete continuous improvement training

Indicator: Percent of Management Staff Completing Mandatory Process Improvement Training



	Actual	Target
12-Q3	0	**100**
12-Q4	0	**100**
13-Q1	100	**100**
13-Q2	100	**100**
13-Q3	108	**100**

Interpretation - Patient And Business:

97 Leaders have completed the continuous improvement training, however only 21% have completed the requirements of completing one improvement cycle using a PDSA and participating in a value stream mapping exercise. 70 Leaders have a PDSA and value stream map in progress. An extra push is required to complete these requirements in Q4.

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.

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?** Our goal for Q3 had been to submit the Stage 1 submission to the Ministry of Health and Long Term Care (Ministry). While the documents were approved for submission in Q3, the logistics of printing and finalizing the package delayed the submission delivery to the SELHIN until January 14 (Q4).

   The SELHIN will be presenting the KGH Stage 1 submission to their Board on February 25th, 2013. The SELHIN will upon approval direct us to submit the documents to the Ministry, and the SELHIN will send a letter of endorsement to the Ministry.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The Stage 1 documents were completed and approved at the KGH Board Meeting in November (Q3) and Queen's University letter of support for the submission was received on December 11, 2012.

3. **Are we on track to meet the milestone by year end?** Our original goal for Q4 was to receive Ministry approval by the end of Q4 allowing the hospital to begin Stage 2 of the Redevelopment process. The Ministry will likely receive the submission in late February and our efforts will then turn to support the Ministry review of the material.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Senior Administration and JPO will contact their respective Ministry contacts as soon as they receive our package and begin to support their review. We have over the last few years met with many Ministry and Government representatives to prepare them for the submission. The Minister of Health, the Deputy Minister of Health, Ministry Capital Branch staff and Infrastructure Ontario Leadership have all toured our facilities to see the issues we are trying to address in Phase 2. In addition John Garretson, MPP for Kingston and the Islands has been toured and kept apprised of the progress. Mayor Mark Garretson will be touring the facilities in February 2013. In parallel with these effort we have begun to plan for Stage 2, creating a plan to support the organization fulfill the requirements, including functional planning.

Kingston General Hospital

MS #21

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

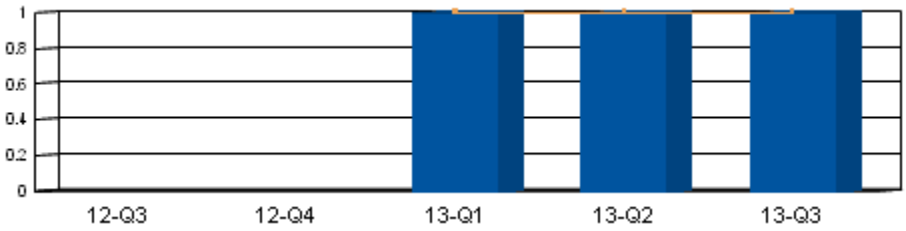
Kingston General Hospital

MS #21

Facilities

Phase 2 redevelopment functional programming commences

Indicator: Phase 2 Redevelopment Project Targets are Met



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

Interpretation - Patient And Business:

The Stage One Proposal has been submitted to the LHIN and is being tabled for approval at the LHIN Board meeting in February. MOHLTC review will follow LHIN endorsement.

Actions & Monitoring Underway to Improve Performance:

MOHLTC approval is required prior to proceeding with the development of the "Stage Two: Functional Program". The JPO is working with each program to structure their programming/planning teams, identify research/best practice opportunities, and efficiency reviews prior to commencement of programming.

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.

Carpets are removed from 75% of patient areas

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

Indicator
Quarterly Carpet Removal Targets are Met

1. **What is our actual performance on each of the indicators for this milestone as listed above?** As at the end of December 2012 (Q3) we have completed 55% of the carpet removal and are on target.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The positive results are the result of ongoing collaboration between the JPO staff and hospital support and clinical departments. Good project management and communication have been important to the success to date.

3. **Are we on track to meet the milestone by year end?** Yes
   Our plan is to have completed 75% of the removal by March 31, 2013 and we do not see any issues at present that would impact meeting this target.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** JPO is overseeing the contractor relationship and ensuring schedules are aligned and also coordinating other work required in the respective parts of the hospital having carpet removal in Q4. This is always a challenging exercise given the moves and realignment of supplies and staff flows across the hospital.

Kingston General Hospital

MS #22

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

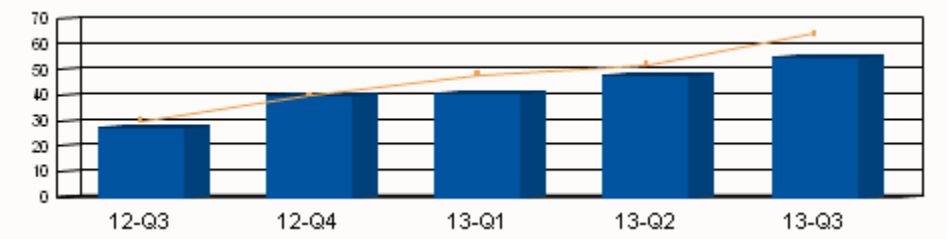
Kingston General Hospital

MS #22

Facilities

Carpets are removed from 75% of patient areas

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
12-Q3	27	**30**
12-Q4	40	**40**
13-Q1	41	**48**
13-Q2	48	**52**
13-Q3	55	**64**

Interpretation - Patient And Business:

The project is on budget and inpatient unit progress is on schedule. The reason for not meeting target continues to be the lag in some non-patient areas (e.g. the Kidd 1 and Kidd 2 hallways). Upon completion of these areas in Q4, the Q4 target of 76% will be met.

Actions & Monitoring Underway to Improve Performance:

The planning team will continue to monitor progress to maintain the inpatient unit completion schedule on time and on budget.

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%)

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?** Third quarter result of 40% represent a modest improvement over the previous quarter. The month of December's performance of 47% was a marked improvement, but did not compensate for lower performance earlier in the quarter. Overall chart deficiencies remain within target supporting operational and financial improvements in the Health Information Service department.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The ongoing concern that has been raised by physicians is the lack of direct notification to physicians that they have outstanding Discharge Summaries to approve that are approaching the 72 hour threshold.

3. **Are we on track to meet the milestone by year end?** While improved communication is resulting in the improvement noted in Q3. Our goal for year end is still to make major progress towards the target.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** An analysis of our Q3 performance indicates the majority of all discharge summaries continue to be complete and available for patients at time of discharge. Attending physician signature compliance within the 72 hour target continues to challenge performance and delay distribution to primary care. Health Information Services and Medical Administration continue to sanction as per policy. As a new initiative the Joint Quality and Utilization Improvement Committee (JQUIC) will ensure that individual department quality improvement plans are aligned in Q4 to ensure performance targets are met. To support JQUIC, reports have been developed to monitor department and individual physician performance. Information Management will work with departments to roll out inbox technology over the next 12 weeks. This technology will enable a real time process to identify and verify unsigned discharge summaries.

Kingston General Hospital

MS #23

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

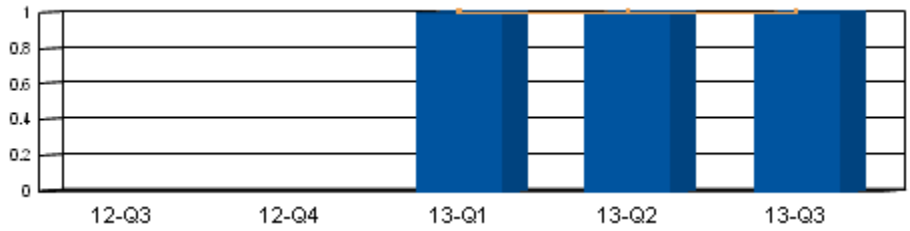
Kingston General Hospital

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

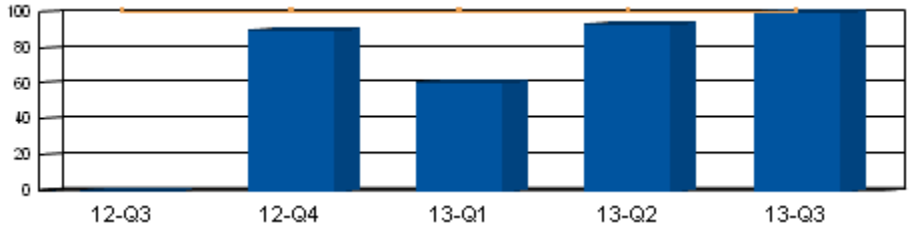
Interpretation - Patient And Business:

Test cabinet in place within Pharmacy; ER replacement cabinets have been delivered and will be first location to go live; order of implementation determined by group; education plan; staff satisfaction surveys; policy reviews underway.

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-Q3	0	**100**
12-Q4	90	**100**
13-Q1	60	**100**
13-Q2	93	**100**
13-Q3	100	**100**

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

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

Target: Target 11/12: 100% of inpatients. Updated Target 12/13: 100% (all remaining patient areas)

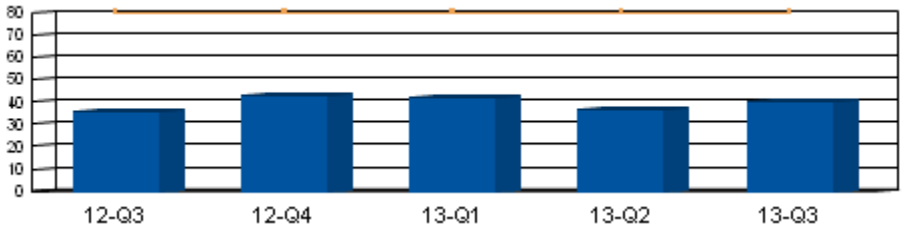
Kingston General Hospital

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-Q3	36	**80**
12-Q4	43	**80**
13-Q1	42	**80**
13-Q2	37	**80**
13-Q3	40	**80**

Interpretation - Patient And Business:

Third quarter results of 40% represent a modest improvement over the previous quarter. December's performance of 47% was a marked improvement but did not compensate for lower performance earlier in the quarter. Overall chart deficiencies remain within target supporting operational and financial improvements in the Health Information Service department.

Actions & Monitoring Underway to Improve Performance:

An analysis of our Q3 performance indicates the majority of all discharge summaries continue to be complete and available for patients at time of discharge. Attending physician signature compliance within the 72 hour target continues to challenge performance and delay distribution to primary care. Health Information Services and Medical Administration continue to sanction as per policy. The Joint Quality and Utilization Improvement Committee (JQUIC) will ensure that individual department quality improvement plans are aligned to ensure performance targets are met. To support JQUIC, reports have been developed to monitor department and individual physician performance. Information Management will work with departments to roll out inbox technology over the next 12 weeks. This technology will enable a real time process to identify and verify unsigned discharge summaries.

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%

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?** Our goal for Q4 was $15 million by March 31 available for capital purchases. As at the end of Q3 we had reached $15 million.

2. **What are the contributing factors to the current performance of the indicators for this milestone?** The ongoing due diligence of our CFO and Capital Committee have maintained a constant vigilance including looking for opportunities to augment the capital budget. Funds have been secured through operational efficiencies found during the year, foundations, and grants (such as Hospital Infrastructure Renewal Fund (HIRF).

3. **Are we on track to meet the milestone by year end?** Yes
We have achieved the $15 million target of fund available for spending in 2012/13. We also have at this point in our budget process identified in the budget for 2013/14 an opening funds available of $15.5 million.

4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?** Work will continue in our finance and operational performance to oversee the budget development and all leaders are aware of the targets and need for capital investment. This will continue to be a focus of our quarterly reporting for management for the upcoming year.

Kingston General Hospital

MS #24

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	G	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 ↓

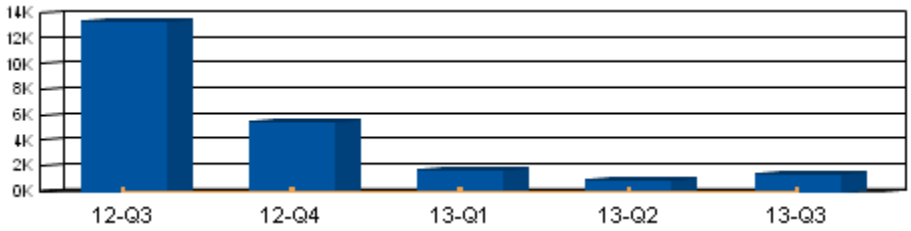
Kingston General Hospital

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-Q3	13,359	**0**
12-Q4	5,532	**0**
13-Q1	1,651	**0**
13-Q2	941	**0**
13-Q3	1,411	**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.

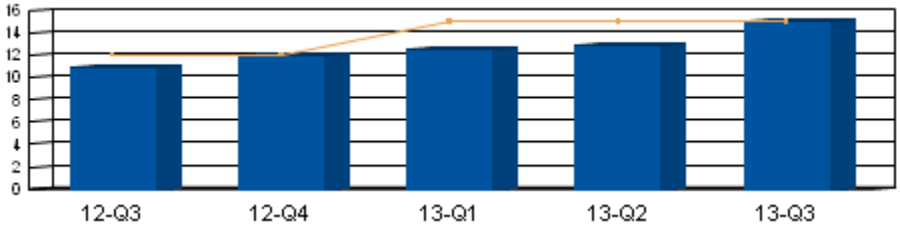
Actions & Monitoring Underway to Improve Performance:

The Q3 results indicate a total variance to plan of $4.1 million. One-time revenues and favourable variances from position vacancies and various corporate support operating expenses are offsetting unfavourable results in patient revenue 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-Q3	11.0	**12**
12-Q4	12.0	**12**
13-Q1	12.5	**15**
13-Q2	12.9	**15**
13-Q3	15.0	**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 has achieved the targeted $15.0 capacity for investment in capital for fiscal 2013 including the anticipated support from the Ministry health Infrastructure Renewal Fund.

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

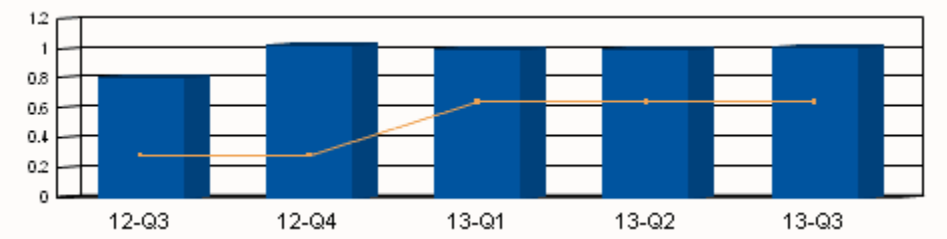
Kingston General Hospital

MS #24

Finances

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

Indicator: Current Ratio



	Actual	Target
12-Q3	0.80	**0.28**
12-Q4	1.02	**0.28**
13-Q1	0.99	**0.64**
13-Q2	0.99	**0.64**
13-Q3	1.01	**0.64**

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.

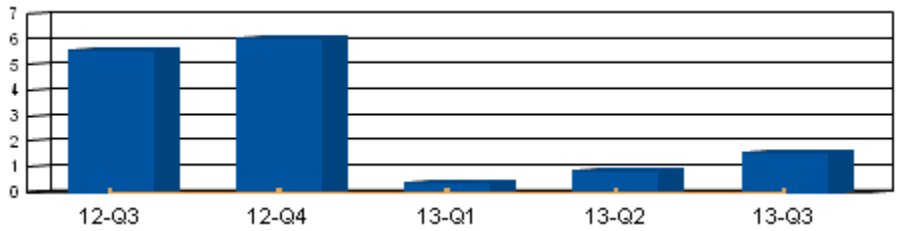
Actions & Monitoring Underway to Improve Performance:

The Q3 current ratio exceeds the fiscal 2013 target. This ratio is expected to decline as cash held for capital expenditure and other restricted purposes is utilized.

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-Q3	5.6	**0**
12-Q4	6.0	**0**
13-Q1	0.3	**0**
13-Q2	0.8	**0**
13-Q3	1.6	**0**

Interpretation - Patient And Business:

Note: Year-end target for Total Margin is 0. Q3 Target is 0.28 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 Q3 results indicate a total margin of $2.5 million; a favourable variance to plan of $4.1 million. One-time revenues and favourable variances from position vacancies and various corporate support operating expenses are offsetting unfavourable results in patient revenue 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

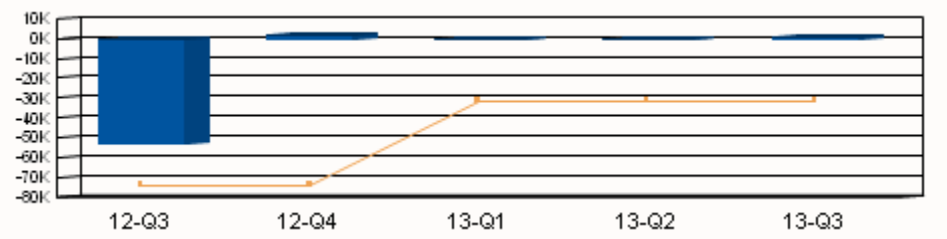
Kingston General Hospital

MS #24

Finances

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

Indicator: Working Capital ($000's)



	Actual	Target
12-Q3	-53,191	**-74000**
12-Q4	2,035	**-74000**
13-Q1	-601	**-31500**
13-Q2	-481	**-31500**
13-Q3	610	**-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 $601 thousand working capital surplus reflects the unadjusted position. As cash held for capital expenditure and other restricted purposes is utilized the working capital position will decline. The "adjusted" working capital deficit (excluding funds held for capital investment or other restricted purposes) at Q3 is -$53.4 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)

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 will not be available in this fiscal year.
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?**
   Due to the decision to delay delivery of the next Workplace Pulse survey, we are not on track to meet this milestone by year end, however a number of initiatives are underway to improve staff satisfaction with communication at KGH.
4. **What specific actions, initiatives or projects are planned/underway to ensure this milestone is met?**

To support the organization in achieving this milestone, there are a number of specific tactics underway to improve internal communication. 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-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	R	R	R	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

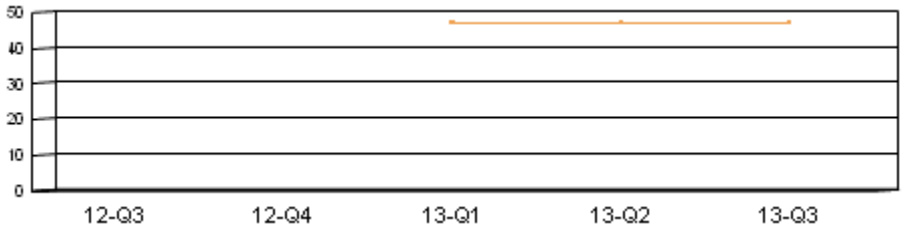
Kingston General Hospital

MS #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-Q3		
12-Q4		
13-Q1	47	
13-Q2	47	
13-Q3	47	

Interpretation - Patient And Business:

In Q3 we developed communications to support the management of the influenza outbreak which was widely reported in the news. Our communication plan included extensive staff and public education to help individuals understand how to respond to the flu outbreak. We played an active role in planning the KGH Community Showcase including a comprehensive plan for branding, positioning and communicating the event to staff to encourage awareness and participation. Planning for an international conference on patient- and family-centred care kicked off, including a branding and marketing-communication plan for outreach across the healthcare community in Canada. The conference is designed to bring healthcare professionals together to exchange knowledge about patient- and family-centred care strategies. We created a proactive media awareness campaign to shine the spotlight on the work of KGH researcher Elaine Petrof around her collaborative study on synthetic stool for the treatment of C. Difficile. This elicited a great deal of national and international media attention. We also developed a communication strategy for the development of two websites that KGH received funding to create – one to promote mental health awareness in our workplace and another to deliver a cultural diversity education program for staff.

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

Strategy Performance Report - Fiscal 2012/13 Q3

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
KGH 2015	100% Accreditation Canada Requirements are Met with an Unconditional Three-Year Award	100% Accreditation Canada Requirements Met	N/A	N/A	G	G	G	↑
	Quality Improvement Plan Targets are Met	Number of Quality Improvement Plan Goals for Change Met	N/A	N/A	Y	Y	G	↑
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	R	N/A	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	Y	G	↑
	The number of new patients who acquire infections in our hospital is reduced by 10%	Number of New Cases of Hospital Acquired Infection	Y	R	G	R	R	↓
	KGH overall average length of stay is better than expected length of stay	Average # ALC Patients per Day	G	G	R	R	R	↓
		Overall - Acute Average Length of Stay vs ELOS Variance in Days - QIP *	G	G	Y	Y	G	↑
	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	Y	R	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	Y	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	R	Y	Y	↑

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
Cultivate patient oriented research	Clinical research space at KGH increases by 25%	8% Increase of Externally Funded Research Dollars at KGH	G	G	N/A	G	G	↑
		Square Footage of Clinical Research Space at KGH	N/A	N/A	N/A	N/A	Y	
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	G	G	G	G	G	↑
	Evidence-based guidelines are adopted in 12 clinical areas	Number of Clinical Areas that have Implemented Open Source (OS)	G	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	R	N/A	N/A	N/A	
	Health and Safety Scorecard targets are met	Number of Health & Safety Scorecard Target Indicators Met	N/A	N/A	G	Y	R	↓
	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	R	R	
Processes	100% of KGH managers complete continuous improvement training	Percent of Management Staff Completing Mandatory Process Improvement Training	R	R	G	G	G	↑
Facilities	Phase 2 redevelopment functional programming commences	Phase 2 Redevelopment Project Targets are Met	N/A	N/A	G	G	G	↑
	Carpets are removed from 75% of patient areas	Quarterly Carpet Removal Targets are Met	G	G	Y	G	Y	↑
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	G	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	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

QIP - Fiscal 2012/13 Q3

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
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	Y	G	G	N/A	↑
		Percent of Clinical Programs that Have Conducted at Least One Patient and Family Feedback Forum *	N/A	N/A	G	G	G	↑
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey *	R	R	R	R	R	↑
	Patient safety culture ratings improve by 20%	Number of Clinical Programs that Implement at Least One New Safety Checklist	N/A	N/A	G	G	G	
		Implementation of Surgical Safety Check List	G	G	G	G	G	↑
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data *	R	R	N/A	N/A	N/A	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) *	Y	Y	R	R	R	↑
		Hospital Standardized Mortality Ratio (HSMR)	R	G	N/A	N/A	N/A	↑
		Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey *	G	G	Y	Y	N/A	↓
		Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations *	N/A	N/A	G	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 *	R	Y	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	Y	R	R	↑
		Hand Hygiene Compliance *	G	G	Y	Y	G	↑
	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	Y	Y	G	↑

			12-Q3	12-Q4	13-Q1	13-Q2	13-Q3	
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile *	G	G	R	Y	G	↑
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility *	Y	Y	N/A	N/A	N/A	↑
	The emergency department wait time for admitted patients is improved by 20%	90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	G	G	Y	R	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	
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	R	Y	Y	↑
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

Occupational Health and Safety Scorecard

				12-Q1	12-Q2	12-Q3
Health and Safety	Health & Safety		OHS - # MOL Orders Issued	G	G	R
			OHS - 21 Day Management Response to JHSC Identified Hazards	R	R	R
			OHS - Cases of Possible/Confirmed Cases of Occupational Illness Reported to MOL	G	G	G
			OHS - Completion of Pre-Placement Health Screening	G	G	G
			OHS - Days Lost Due to Workplace Injury/Illness	G	Y	R
			OHS - High Risk Occupational Exposures Reported to MOL	Y	G	G
			OHS - Incidence of all MSI Injuries (MSI's)	Y	R	R
			OHS - Incidence of Needlestick Injuries (NSIs)	Y	R	R
			OHS - Incident Investigations Complete	R	R	R
			OHS - JHSC Monthly Workplace Inspections	G	G	G
			OHS - Lost Time Injury/Illness Claims	G	G	G
			OHS - Management Workplace Inspections	R	R	R
			OHS - Mandatory Safety Training	Y	Y	Y
			OHS - MOL Reported Critical Injury	G	G	G

				12-Q1	12-Q2	12-Q3
Health and Safety	Health & Safety		OHS - MSI Lost Time Injury Claims (LTIs)	G	G	G
			OHS - Respirator Fit Testing & Training Completion	R	R	Y
			OHS - WSIB Healthcare Claims	Y	R	R
			OHS - WSIB NEER Performance Index - 2008	Y	Y	Y
			OHS - WSIB NEER Performance Index - 2009	Y	Y	Y
			OHS - WSIB NEER Performance Index - 2010	G	G	G
			OHS - WSIB NEER Performance Index - 2011	G	G	G

Indicates worsening performance to target over the past 5 quarters

Indicates improving performance to target over the past 5 quarters

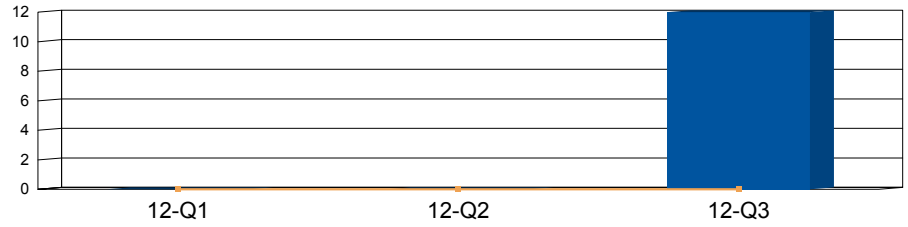
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - # MOL Orders Issued



	Actual	Target
12-Q1	0	**0**
12-Q2	0	**0**
12-Q3	12	**0**

Interpretation - Patient And Business:

2 visits in Q3- one in relation to the Hydroclave in Environmental Services and the other in realtion to KGH's TB Control Program which resulted in orders with respect to negative pressure isoaltion rooms.

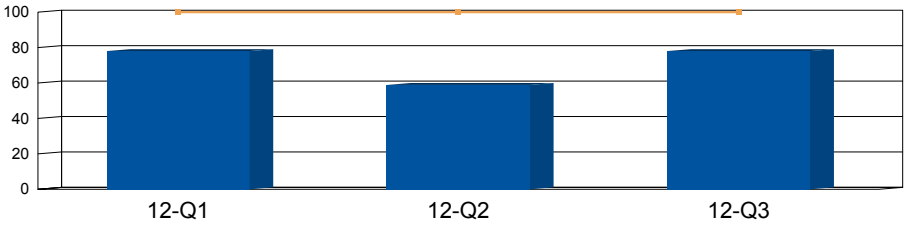
Actions & Monitoring Underway to Improve Performance:

A new policy and procedure was put in place for the Hydroclave as were a number of safety measures with repect to guarding and lock out. Improvements required on negative pressure rooms (e.g. signage, training) nearly complete.

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

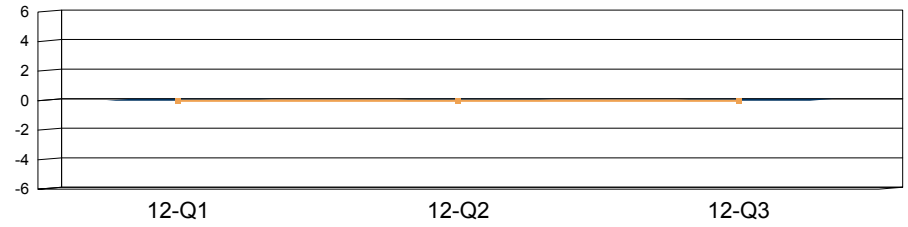


	Actual	Target
12-Q1	78	**100**
12-Q2	59	**100**
12-Q3	78	**100**

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**
12-Q3	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

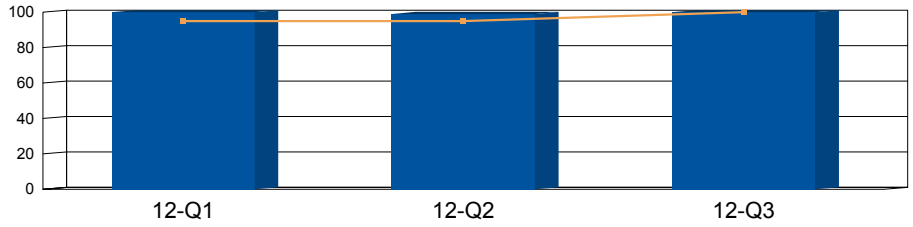
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

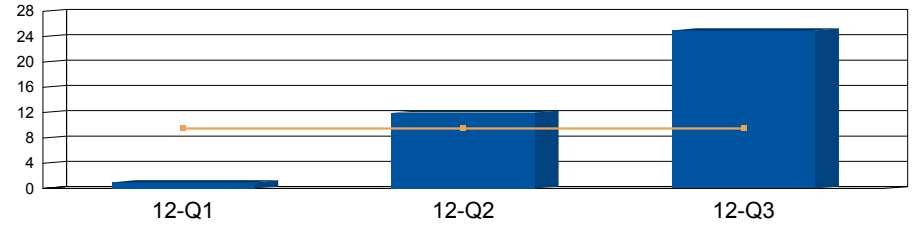
Indicator: OHS - Completion of Pre-Placement Health Screening



	Actual	Target
12-Q1	100	**95**
12-Q2	99	**95**
12-Q3	100	**100**

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



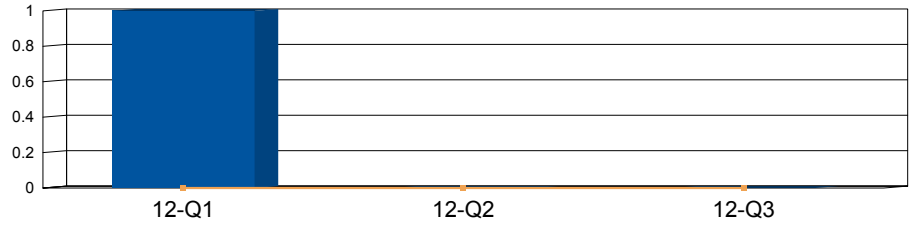
	Actual	Target
12-Q1	1	**9.5**
12-Q2	12	**9.5**
12-Q3	25	**9.5**

Interpretation - Patient And Business:

4 lost time injuries resulting in the 25 days lost - 2 of the LTIs resulted in 23 of the 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**
12-Q3	0	**0**

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

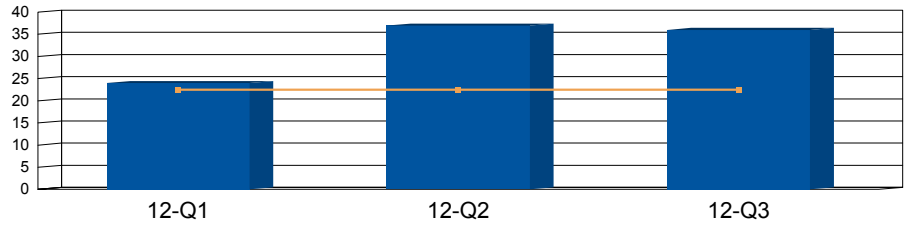
Kingston General Hospital

Occupational Health and Safety Scorecard

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**
12-Q3	36	**22.5**

Interpretation - Patient And Business:

64% of MSIs related to patient handling activities (N=23) with 1 resulting in a lost time injury claim (1 day) and 2 resulting in health care claims.

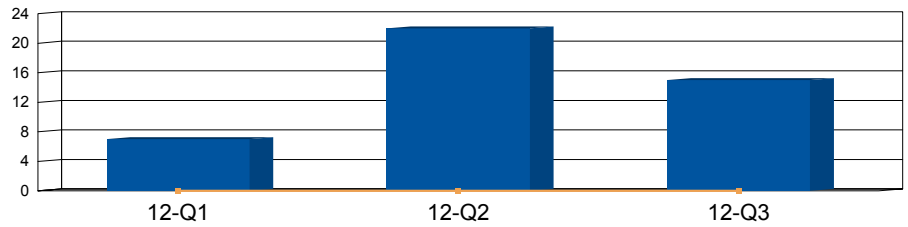
Actions & Monitoring Underway to Improve Performance:

Safe Patient Handling Program under review

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**
12-Q3	15	**0**

Interpretation - Patient And Business:

1/2 of the NSIs were related to failure or improper activation of the safety mechanism. 33% of NSIs in Medicine Program.

Needle Safety Training under development for LMS.

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

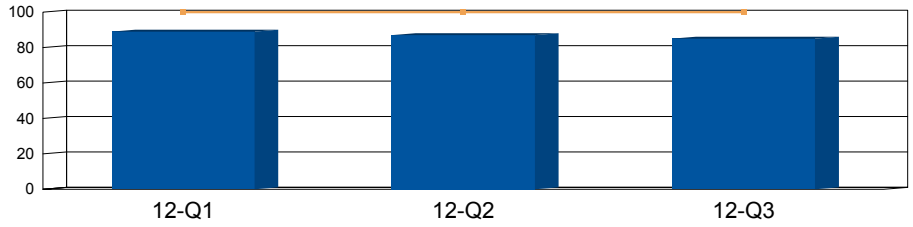
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Incident Investigations Complete



	Actual	Target
12-Q1	89	100
12-Q2	87	100
12-Q3	85	100

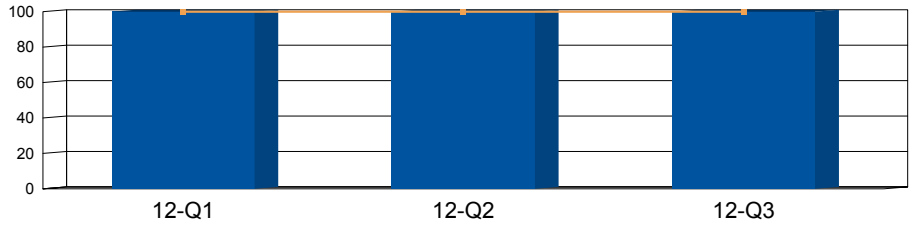
Actions & Monitoring Underway to Improve Performance:

Focus Q4 on Supervisor roles & responsibilities with regard to hazard recognition and control when Safe Reports are submitted.

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

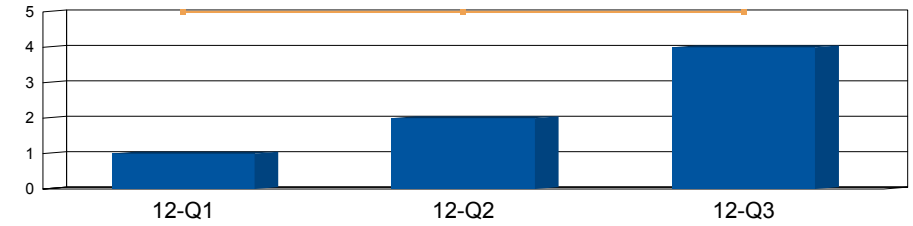


	Actual	Target
12-Q1	100	100
12-Q2	100	100
12-Q3	100	100

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%

Indicator: OHS - Lost Time Injury/Illness Claims



	Actual	Target
12-Q1	1	5
12-Q2	2	5
12-Q3	4	5

Interpretation - Patient And Business:

Causes- 1 Needlestick injury, 1 Head Injury, 2 MSIs- one violence-related and other related to patient handling

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

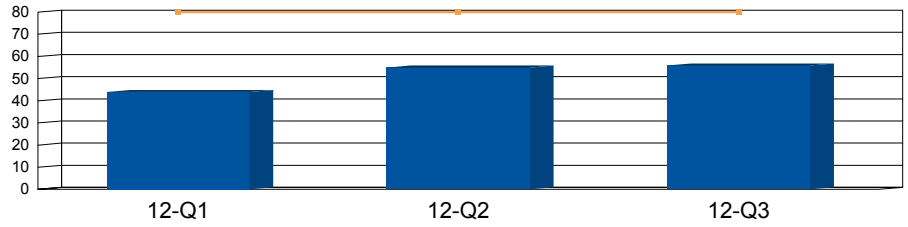
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Management Workplace Inspections



	Actual	Target
12-Q1	44	**80**
12-Q2	55	**80**
12-Q3	56	**80**

Interpretation - Patient And Business:

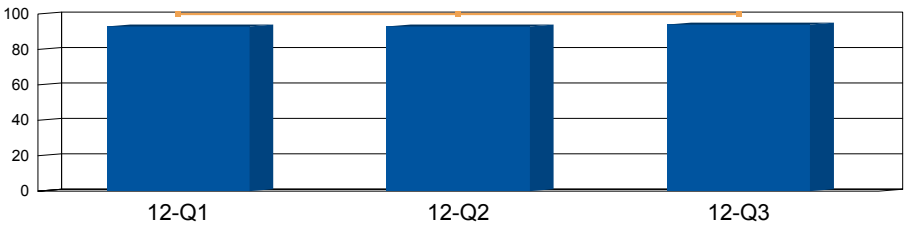
Actions & Monitoring Underway to Improve Performance:

Focus Q4 on Supervisor roles & responsibilities with regard to hazard recognition and control.

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%

Indicator: OHS - Mandatory Safety Training



	Actual	Target
12-Q1	93	**100**
12-Q2	93	**100**
12-Q3	94	**100**

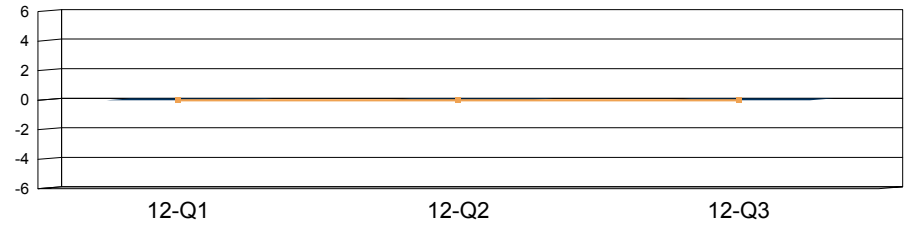
Interpretation - Patient And Business:

WHMIS at 92%, Workplace Violence & Harassment Prevention at 76% and MSI Prevention at 91%.

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**
12-Q3	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

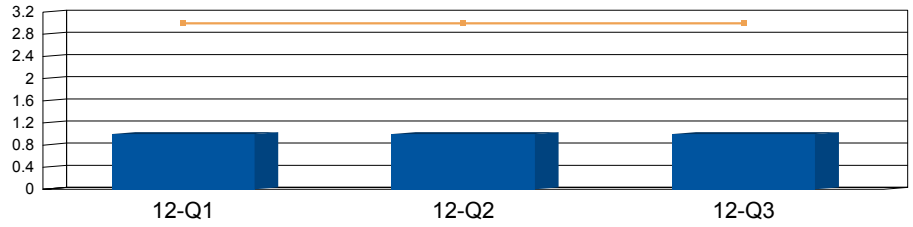
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

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



	Actual	Target
12-Q1	1	3
12-Q2	1	3
12-Q3	1	3

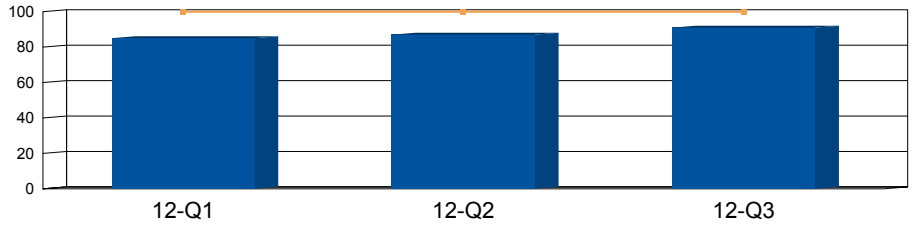
Interpretation - Patient And Business:

Related to patient handling and resulted in 1 lost day

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

Indicator: OHS - Respirator Fit Testing & Training Completion

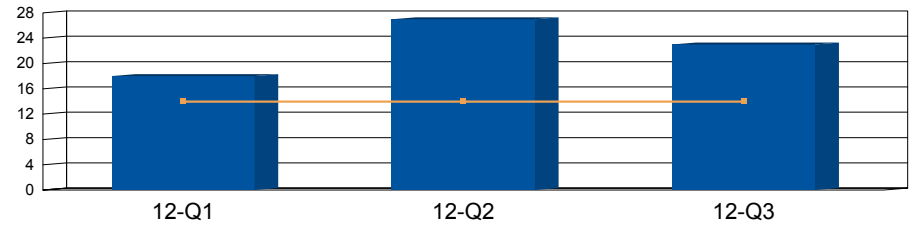


	Actual	Target
12-Q1	85	100
12-Q2	87	100
12-Q3	91	100

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
12-Q3	23	14

Interpretation - Patient And Business:

Top causes: Falls (6),), MSI other (4), occup exposures (3), and physical violence (3)

Actions & Monitoring Underway to Improve Performance:

Focus Q4 on Supervisor roles & responsibilities with regard to hazard recognition and control as the key proactive prevention strategy to reduce incidence of workplace injury/illness.

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

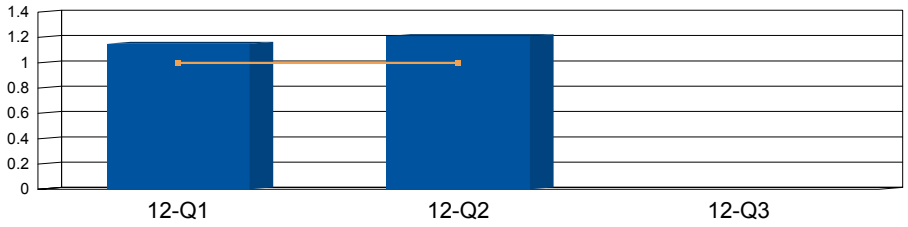
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2008

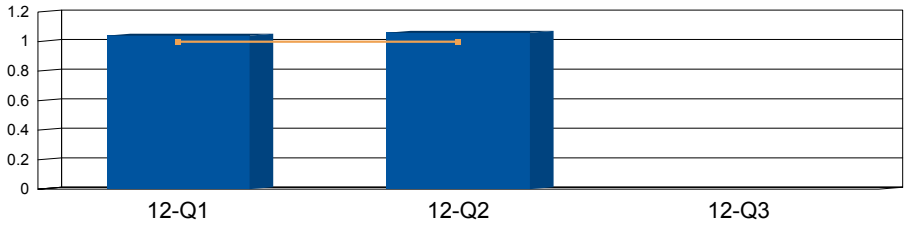


	Actual	Target
12-Q1	1.15	**1**
12-Q2	1.21	**1**
12-Q3		

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

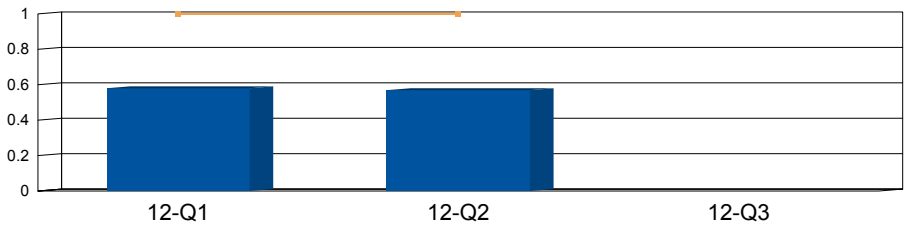


	Actual	Target
12-Q1	1.04	**1**
12-Q2	1.06	**1**
12-Q3		

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	0.57	**1**
12-Q3		

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

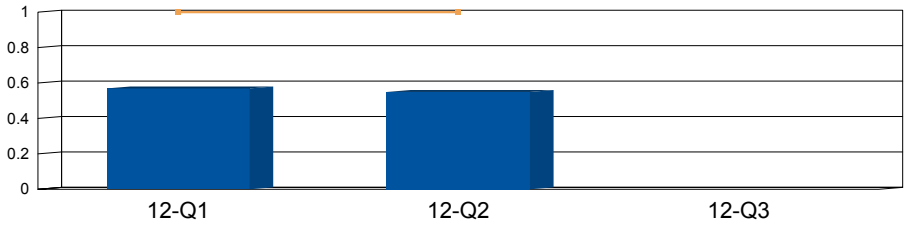
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2011



	Actual	Target
12-Q1	0.57	**1**
12-Q2	0.55	**1**
12-Q3		

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

Status:

Currently Not Available


Green-Meet Acceptable Performance Target


Red-Performance is outside acceptable target range and require


Yellow-Monitoring Required, performance approaching


Blue-Project Completed

Glossary Of Acronyms