fiscal 2013-2014 **Q1**

1st quarter ended June 30, 2013

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

Kingston General Hospital

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Master Performance Report
Q1 Fiscal 2013 - 2014

Strategic Direction 1

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

- Percent of Staff surveyed who rate KGH “very good” or “excellent” on the Patient Safety Culture Survey
- Percent of recommendations considered and acted upon as per critical incident investigations

Milestone 3: The top sources of GRIDLOCK are addressed **Page 23**

- General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) – 90th Percentile Wait Time (Days)
- Percent of recommendations completed as per incident review triggered by Code GRIDLOCK (QIP)
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- Percent ALC days
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KGH Experience Advisors are trained and participate in the Achievement of all improvement priorities

Green

Strategic Direction	KGH 2015 outcome	Indicator
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**	**Percent improvement priorities with Patient Experience Advisors engaged**

Improvement Priorities
Expand the scope of the Patient Experience Advisor Program

1. **What is our actual performance on the indicator for this milestone as listed above?** A work plan has been developed to ensure availability and preparedness of advisors to be engaged in the corporate improvement priorities. Consistent with the work plan, an education program has been developed to support all advisors who have expressed interest about or are already working on Priority Improvement Teams aligned to the initiatives reported to the QPCC, in receiving an orientation to Continuous Improvement and the Value Stream Mapping process. To date 13 advisors have signed up, and 6 have completed the training, with others in progress. An advisor has been part of the overall Gridlock VSM process and 2 advisors are involved in the 5 Gridlock PDSA' s that have been prioritized to proceed, and recruitment is underway for minimum 1 other. At this point, advisors are part of 3 of the 4 teams working on reducing avoidable harm (reducing falls; lab specimens, IV medication events).

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Development of a modified but audience appropriate Continuous Improvement curriculum occurred and been launched. This will continue to be used as current or newly recruited advisors agree to become engaged in priority improvements. Efforts are also underway to recruit advisors, and engagement with improvement priorities is profiled as one of the opportunities. Executive sponsors are mindful and reminded of the expectation of considering and engaging advisors in work that will have a material impact on the patient experience. A mechanism to catalogue CI education and engagement of advisors in initiatives is in development.

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

4. **What new tactics are planned to ensure this milestone is met?**
Continue to support education of advisors as it enables them to be equal partners in the CI/VSM processes; continue with advisor recruitment tactics to ensure advisors are available to consider and become engaged in project work; continue to ensure process to catalogue the work and involvement. It should be noted that advisors are part of many improvement initiatives that extend beyond the corporate priorities reporting to QPCC, and this will continue to be supported. As PDSA cycles conclude, the profile and celebration of the outcomes will be important to further promote both advisor and staff engagement .

Kingston General Hospital

MS #01

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities	Percent Improvement Priorities with Patient Experience Advisors Engaged	N/A	N/A	N/A	N/A	G	
		Overall, How Would You Rate the Care You Received at the Hospital?	G	G	G	G	N/A	↑
		Percent of Patients Who Answer "Definitely Yes" to the NRC Picker Question " Would You Recommend this Hospital to Your Friends and Family?"	G	G	G	G	G	↑
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey	R	R	R	N/A	N/A	↑
		Overall Acute Care Patient Satisfaction (%) - (QIP)	G	G	G	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%) - (QIP)	G	G	G	G	N/A	↑

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

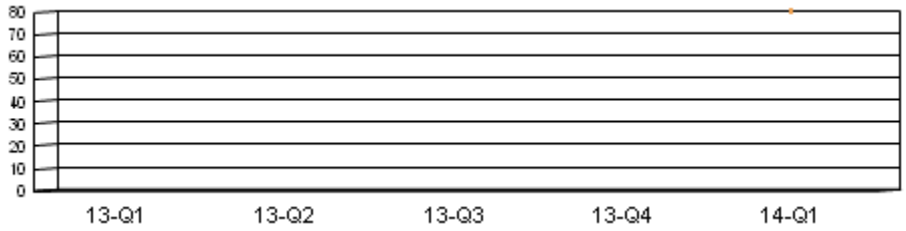
Kingston General Hospital

MS #01

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

KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities

Indicator: Percent Improvement Priorities with Patient Experience Advisors Engaged



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1		**80**

Interpretation - Patient And Business:

Consistent with the work plan, an education program has been developed to support all advisors, who will be working on the Priority Improvement Teams aligned to the initiatives reported to the QPCC, in receiving an orientation to Continuous Improvement and the Value Stream Mapping process. To date 13 advisors have signed up, and 6 have completed the training. An advisor has been part of the overall Gridlock VSM process and 2 advisors are involved in the PDSA cycles that have resulted. At this point, advisors are part of 3 of the 4 teams working on reducing avoidable harm (reducing falls; lab specimens, IV medication events).

Actions & Monitoring Underway to Improve Performance:

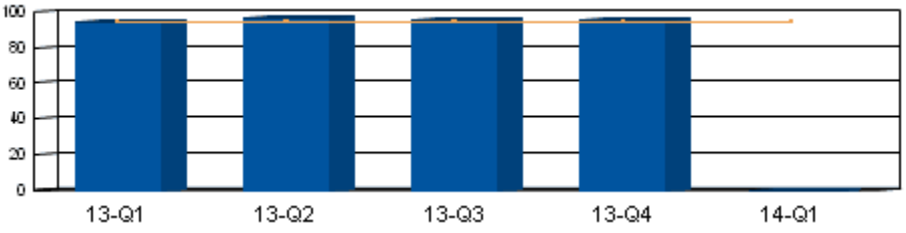
Continue to support education of advisors as it enables them to be equal partners in the CI/VSM processes; continue to recruit advisors to be available to consider and become engaged in project work; continue to ensure process to catalogue the work and involvement. It must also be noted that advisors are part of many improvement initiatives that extend beyond the corporate priorities reporting to QPCC.

Definition: COMMENTS: Eleanor Rivoire

The KGH Strategy is explicit about having patients meaningfully engaged in all aspects of our quality, safety and service improvement initiatives with the view to fundamentally transforming the patient experience. Further there has been commitment to the increase the adoption of continuous improvement principles by ensuring that Plan/Do/Study/Act improvement cycles are applied to all improvement priorities.
By providing Continuous Improvement Training for all Patient Experience Advisors who become involved in the design and implementation of improvement initiatives allows them to work side by side with staff, and assures the input of their unique perspective as quality, safety and service improvement initiatives are undertaken.

Target: Target 13/14: 80% Perf. Corridor: Red <70% Yellow 70%-80% Green >=80%

Indicator: Overall, How Would You Rate the Care You Received at the Hospital?



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

Interpretation - Patient And Business:

Scores reflect 2013 Jan-Mar survey results. 95% represents the combined responses of good, very good and excellent. KGH is on par with the Ontario Teaching Hospital Average target.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong

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 12/13: PTAOB, Target 13/14: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

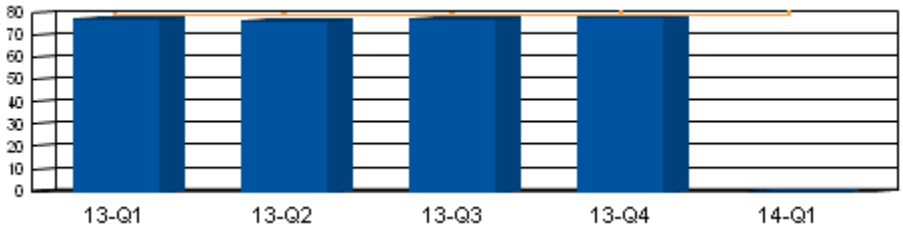
Kingston General Hospital

MS #01

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

KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities

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
13-Q1	77	**79**
13-Q2	76	**79**
13-Q3	77	**79**
13-Q4	78	**79**
14-Q1		**79**

Interpretation - Patient And Business:

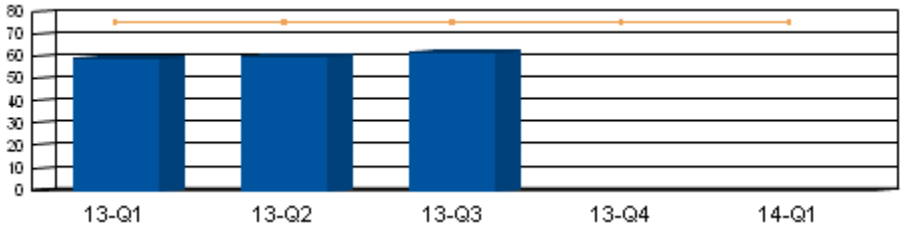
This percent positive score reflects 2013 Jan-Mar survey results. We continue to meet the Ontario Teaching Hospital average.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong

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, Target 13/14: PTAOB Perf. Corridor: Red >10% qtr teach. avg. Yellow Within 10% teach. avg. Green At or Below teach. avg.

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



	Actual	Target
13-Q1	59	**75**
13-Q2	60	**75**
13-Q3	62	**75**
13-Q4		**75**
14-Q1		**75**

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%, Target 13/14: 75% Perf. Corridor: Red <65% Yellow 65%-74% Green >=75%

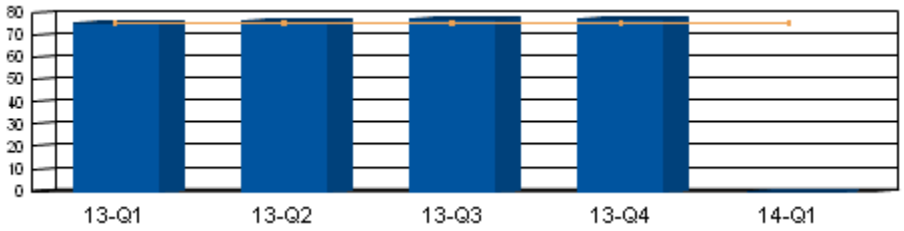
Kingston General Hospital

MS #01

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

KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities

Indicator: Overall Acute Care Patient Satisfaction (%) - (QIP)



	Actual	Target
13-Q1	75	**75**
13-Q2	76	**75**
13-Q3	77	**75**
13-Q4	77	**75**
14-Q1		**75**

Interpretation - Patient And Business:

Scores reflect 2013 Jan-Mar survey results.
Percent positive score is above Ontario Teaching Average target. Increase of 4% in care dimension of 'continuity and transition' this quarter. Other dimensions on par with previous quarter.

Definition: DATA: Astrid Strong COMMENTS: Jennifer Foster

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, Target 13/14: PTAOB Perf. Corridor: Red > 10% qtr teach. target Yellow Within 10% qtr teach. target Green At or above teach. avg./qtr

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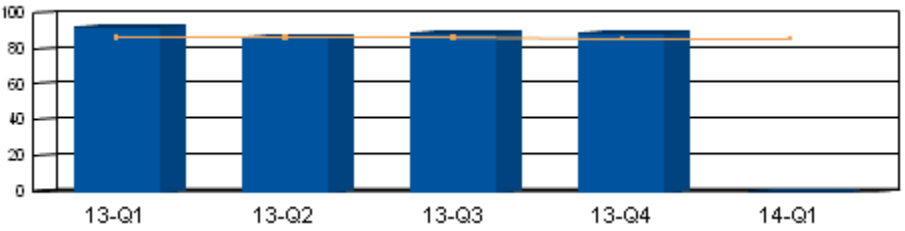
Indicator: Overall Emergency Care Patient Satisfaction (%) - (QIP)



	Actual	Target
13-Q1	92	**86**
13-Q2	86	**86**
13-Q3	89	**86**
13-Q4	88	**85**
14-Q1		**85**

Interpretation - Patient And Business:

Scores reflect 2013 Jan-Mar results. This quarter's positive percent score is above target for Ontario Teaching Hospital Average. On par with last quarter's result.

Actions & Monitoring Underway to Improve Performance:

Definition: DATA: Astrid Strong COMMENTS: Jennifer Foster

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, Target 13/14: PTAOB Perf. Corridor: Red > 10% qtr teach. target Yellow Within 10% qtr teach. target Green At or above teach. avg./qtr

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The top sources of preventable harm to patients are addressed

Yellow

Strategic Direction	KGH 2015 outcome	Indicator
Transform the patient experience through a relentless focus on quality, safety and service	**All preventable harm to patients is eliminated**	**Number of preventable harm to patient indicators met**

Improvement Priorities
Reduce the incidence of specimen collection errors, hospital acquired infections, medication fluid events and falls

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

Milestone 2 is comprised of 23 indicators focused on patient safety and aligned to addressing the top sources of preventable harm to patients. In Q1, 4 indicators have no data available as yet. Of the remaining 19, 14 are green or yellow (74%).

HAI: Green on target. The total number of new infection in Q1 was at target (31). C. difficile rates continue to decline over the last 3 quarters. MRSA rate increased in Q1 (4) however 2 were in patients colonized with MRSA falsely increasing the rate. Admission screening integral to reducing this false data. VRE remains at 0 despite cessation of screening.
Specimen collection errors: **Yellow**. Improvement cycle teams have identified areas of opportunity
Medication Fluid Events: Yellow. Medication safety committee has develop tactics to address medication management standards in keeping with Accreditation Canada.
Falls: Yellow. A Falls Tactic Team has been established. There were 2 level 3 falls in Q1.

2. What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?

Specimen Collection Errors: 3 areas of opportunity with blood collection, glucometers and urine sampling will be addressed
Medication Fluid Events: 1. Implementation of human factor based design of med rooms to support safe handling; 2. Reduction in hydromorphone and morphine errors through automated dispensing cabinets; 3. Strategy for safe management of insulin; 4. Quality assurance program via smart infusion pumps; 5. elimination of anticoagulation errors in epidural patients; 6. prescriber order entry for chemotherapy drug use. to be presented to PSQC for endorsement.
Falls: 1. Mobility Program; 2. Falling Star Program. Both in implementation phase.

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

4. What new tactics are planned to ensure this milestone is met? N/A

Kingston General Hospital

MS #02

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	The top sources of preventable harm to patients are addressed	Number of Preventable Harm to Patient Indicators Met	N/A	N/A	N/A	N/A	Y	
		Reduce the top 3 errors associated with specimen collection	N/A	N/A	N/A	N/A	Y	
		Number of New Cases of Hospital Acquired Infection	G	R	R	G	G	↑
		Reduce the top 3 errors associated with medical fluid events	N/A	N/A	N/A	N/A	Y	
		Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)	N/A	N/A	N/A	N/A	Y	
		Number of Quality Improvement Plan Goals for Change Met	Y	Y	G	G	Y	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	R	R	R	R	R	↑
		Surgical Site Infection (SSI) Prevention	G	G	Y	Y	G	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days - (QIP)	Y	G	Y	G	Y	↑
		C-Difficile (Reported Monthly)	R	R	R	R	R	↓
		C-Difficile (Reported Quarterly)	Y	R	R	Y	R	↓
		Central Line Bloodstream Infections	G	Y	G	G	G	↓
		MRSA (Methicillin-resistant Staphylococcus Aureus)	Y	Y	R	R	R	↓
		Ventilator Associated Pneumonia	R	G	G	G	R	↓
		VRE (Vancomycin-resistant Enterococcus)	R	Y	R	R	G	↑

8	13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
External Environmental Audits by Westech	Y	Y	N/A	Y	N/A
Hand Hygiene Compliance - (QIP)	Y	Y	G	Y	Y
Hospital Standardized Mortality Ratio (HSMR)	G	G	R	N/A	N/A
Percent of Recommendations Completed as per Critical Incident Review Triggered by Mortality Within 5 Days of Major Surgery - (QIP)	N/A	N/A	N/A	N/A	N/A
Percent Mortality Reviews Completed with Review of Record Level HSMR Data - (QIP)	R	R	N/A	N/A	N/A
Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	Y	Y	Y	G	N/A
Percent of Staff Surveyed Who Rate KGH "Very Good" or "Excellent" on the Patient Safety Culture Survey	N/A	N/A	N/A	N/A	N/A
Percent of Recommendations Considered and Acted Upon as per Critical Incident Investigations	N/A	N/A	N/A	N/A	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

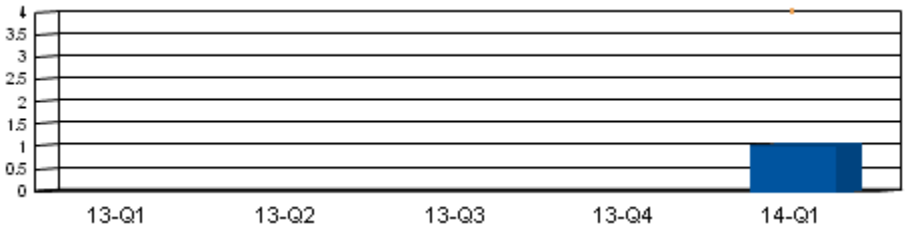
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Number of Preventable Harm to Patient Indicators Met



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	1	4

Interpretation - Patient And Business:

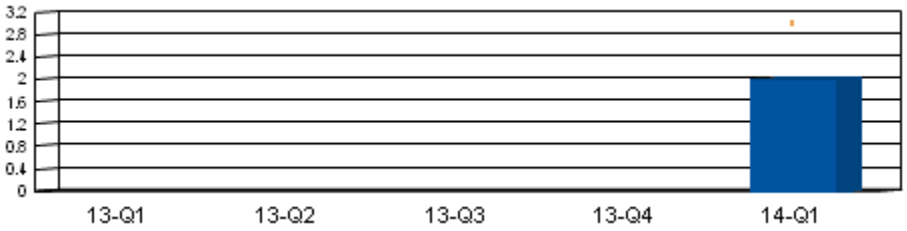
Teams to address Falls, Medication IV Fluid Events and Lab Specimen Collection Errors have met to determine the improvement cycles for this fiscal year. Efforts to date have not been coordinated. Meetings took place with accountable leaders for each of the areas of focus and a plan forward has been established. Work has commenced on improvement cycles and an update will be provided to the Patient Safety Quality Committee in September.

Definition: DATA: Jennifer Foster COMMENTS: Jennifer Foster

This indicator is a roll up indicator of four preventable harm to patient indicators: Medication Fluid Events, Lab Specimen Collection Errors, Patient Falls, and Number of New Cases of Hospital Acquired Infections. These four were selected on the basis of being the highest priority for the organization as it relates patient safety and the quality of care. Continuous Improvement techniques will be applied to address the issues that are contributing to the current performance of the areas.

Target: Target 13/14: 4 Supporting indicators=Green Perf. Corridor: Red: >=3 red indicators Yellow >=3 yellow indicators Green >=3 green indicators

Indicator: Reduce the top 3 errors associated with specimen collection



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	2	3

Interpretation - Patient And Business:

The three areas that have been identified as opportunities for improvement for fiscal 2013/14 are 1. Blood Collection, 2. Glucometers and 3. Urine Samples There will be improvement cycle teams focused on addressing each of these areas.

Definition: COMMENTS: Joyce deVette-McPhail

Using our incident reporting system we have identified that Specimen Collection errors are one of the top three sources of preventable harm to patients for 2012-13 at KGH. KGH had a total of 2299 specimen collection errors in Fiscal 2012-13. The top specific types were deviation from standard operating procedure (659), ID/specimen mismatch (261), specimen leaking / ruined (255), specimen unlabeled (198), requisition incomplete (196), specimen improper collection (181).

Target: Target 13/14: 3 Perf. Corridor Red <=1 Yellow 2 Green 3

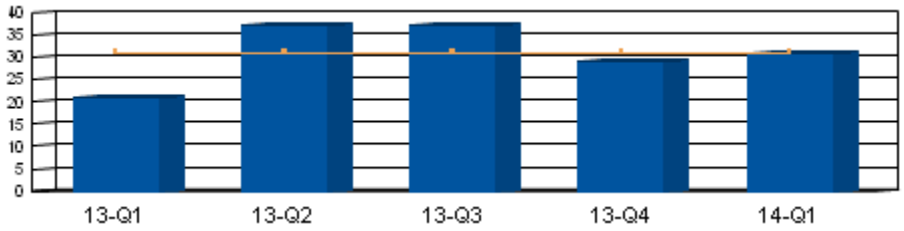
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Number of New Cases of Hospital Acquired Infection



	Actual	Target
13-Q1	21	**31**
13-Q2	37	**31**
13-Q3	37	**31**
13-Q4	29	**31**
14-Q1	31	**31**

Interpretation - Patient And Business:

Patient Perspective: Reduction in total HAIs has an important impact on patient safety and improves the patient's expectation of harm reduction during their hospital journey.

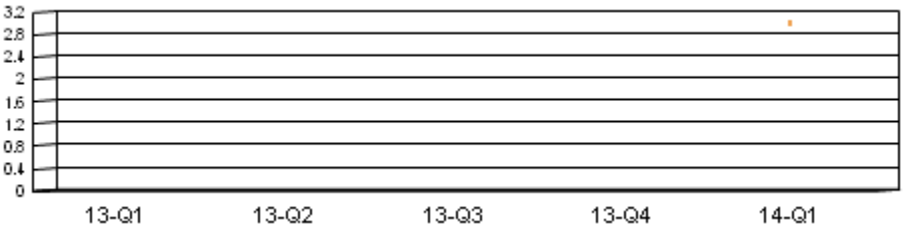
Business Perspective: High levels of hand hygiene, appropriate staffing of IPAC and the institution of an Antibiotic Stewardship program have all helped to reduce transmission of HAIs across the institution. The target reduction has been achieved principally due to a decrease in CDI infections over the last 12 months coupled with stable rates of MRSA and VRE bacteremias.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans

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, Target 13/14: 31 Perf. Corridor: Red >35 Yellow 32-35 Green <=31

Indicator: Reduce the top 3 errors associated with medical fluid events



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	**3**	

Interpretation - Patient And Business:

Improvement Opportunities for the year will focus on the following 6 Tactics with criteria for selection as: Current active projects (either in the development phase or ongoing), Focus on high risk medications as per Accreditation Canada's new Medication Management Standards, Alignment with findings from the Medication Safety Committee (MSC) Quarterly Medication Occurrence reports. In Q3, 3 of the following tactics will be identified as the focus for F2013-14: 1. Implement human factor based design of medication rooms to support safe handling of medications on patient care units. 2. Reduce the incidence of morphine and hydromorphone administration errors through the implementation of automated dispensing cabinets. 3. Implement a comprehensive strategy for the safe management of insulin, including standardization of prescribing, storage, dispensing and administration processes. 4. Implement a quality assurance program to continuously monitor and improve the safe administration of intravenous medications via smart infusion pumps. 5. Implement a sustainable process improvement to eliminate the prescribing of anticoagulants to patients with an epidural in situ. 6. Support evidence-based, safe chemotherapy drug use through the implementation of computerized prescriber order entry for inpatient Oncology via OPIS 2005. Proposed Tactics and improvement cycles will be presented to the Patient Safety Quality Committee in September for endorsement and support.

Definition: COMMENTS: Veronique Briggs

Using our incident reporting system we have identified that Mediation / IV Fluid Events are one of the top three sources of preventable harm to patients for 2012-13 at KGH. KGH had 1405 medication fluid events in 2012-13.
Focus on high risk medications as per Accreditation Canada's new Medication Management Standards, Alignment with findings from the Medication Safety Committee (MSC) Quarterly Medication Occurrence reports.

Target: Target 13/14: 3 Perf. Corridor: Red <=1 Yellow 2 Green 3

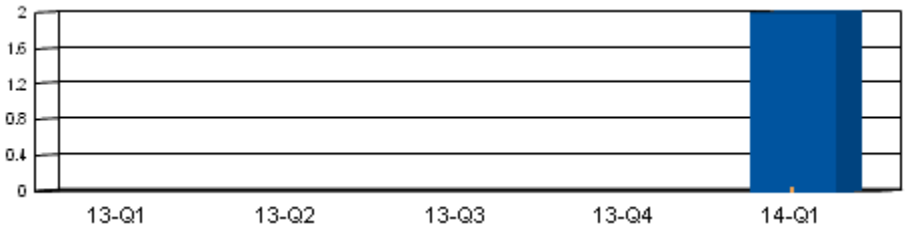
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	2	0

Interpretation - Patient And Business:

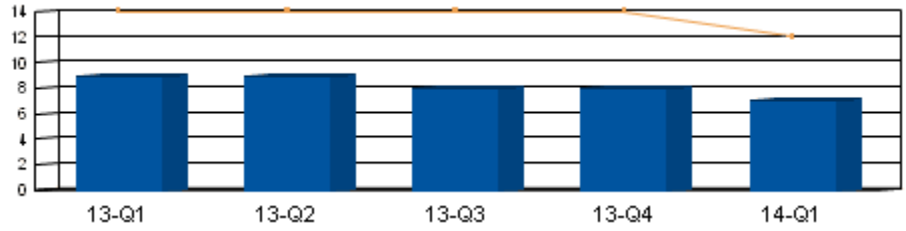
A Falls Tactic Team has been established and improvement cycles for Mobility and the Falling Star Program are in pilot phase. The team will be identifying other opportunities for improvement and presenting these to the Patient Safety Quality Committee in October. We have had two Level Three Falls to date (one in April and one in May). Program level quality of care reviews were completed for both incidents and recommendations implemented.

Definition: DATA: BJ Jackson COMMENTS: Jennifer Foster

Using our incident reporting system we have identified that Falls are one of the top three sources of preventable harm to patients for 2012-13 at KGH. KGH had 11 level 3 Falls and 0 level 4 Falls in Fiscal 2012-13. Our objective for Fiscal 2013-14 is to have Zero Level 3 & 4 Falls.

Target: Target 13/14: 0 Perf. Corridor: Red >3 Yellow 1-3 Green 0

Indicator: Number of Quality Improvement Plan Goals for Change Met



	Actual	Target
13-Q1	9	14
13-Q2	9	14
13-Q3	8	14
13-Q4	8	14
14-Q1	7	12

Interpretation - Patient And Business:

Six new Quality Based Procedure teams have been created and are in process of utilizing the MoHLTC toolkits to set out initiatives to meet volumes and quality metrics.

Actions & Monitoring Underway to Improve Performance:

Based upon experience from the first year of the Orthopedic QBP, critical to the success of all the Quality Based Procedure teams will be the linkage to Medical Records and the data capture process.

Definition: DATA: Decision Support COMMENTS: Dr.David Zelt

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, Target 13/14: 12 of 12 Perf. Corridor: Red <6 Yellow 6-8 Green >=9

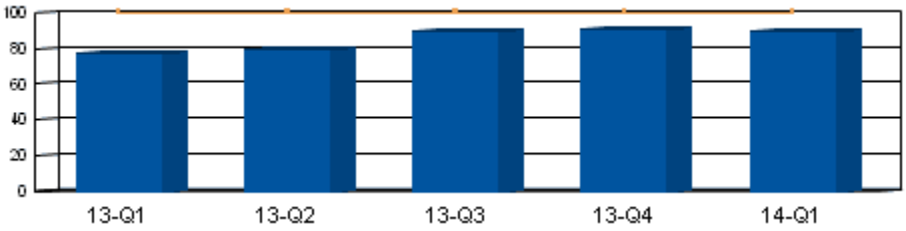
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

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



	Actual	Target
13-Q1	77	**100**
13-Q2	80	**100**
13-Q3	90	**100**
13-Q4	91	**100**
14-Q1	90	**100**

Interpretation - Patient And Business:

Overall the compliance for all services to complete the 3 phases of the surgical safety checklist for all operative activity (urgent, elective) for this quarter (2,327 cases) is the following: Briefing - 97%, Timeout- 98% and the final Debrief - 92%. Focus on urgent/emergent activity SSCL reporting continues in order to meet the overall average target of 100%.

Actions & Monitoring Underway to Improve Performance:

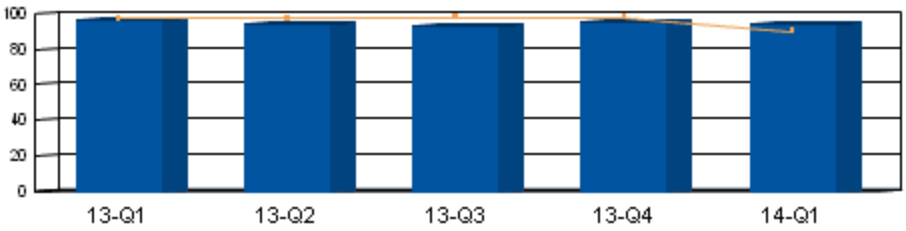
Ongoing education and continuous monitoring is being supported by the program to assist the following services in improving their compliance in completing the 3 phases of SSCL reporting for urgent activity in the operating room.

Definition: DATA: Kathleen Wattie Barnett COMMENTS: Kellie Kitchen

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% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%

Indicator: Surgical Site Infection (SSI) Prevention



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

Interpretation - Patient And Business:

Patient Perspective: Real time electronic documentation of the OR record was implemented during this quarter and as result the month of June had 100% compliance.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans

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 Target 13/14: PAOB Perf. Corridor: Red <10% Prov. Rate Yellow Within 10% Prov. Rate Green >= Prov. Rate

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Kingston General Hospital

MS #02

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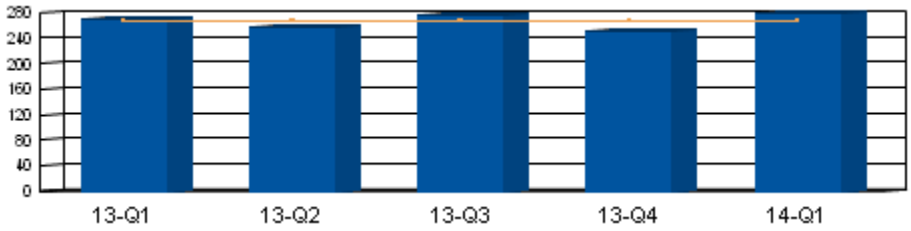
Indicator: Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days - (QIP)



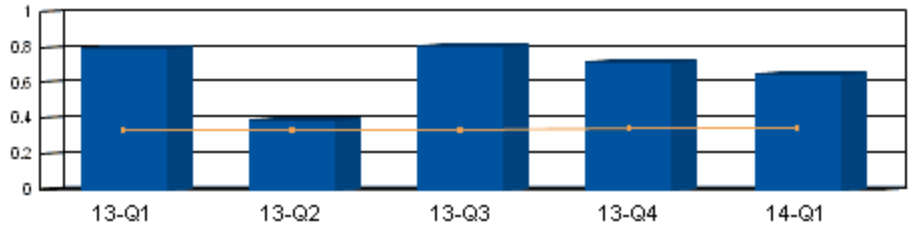
	Actual	Target
13-Q1	271	**267**
13-Q2	257	**267**
13-Q3	275	**267**
13-Q4	252	**267**
14-Q1	278	**267**

Definition: DATA: Susan McKenna COMMENTS: Dr.Gerald Evans

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: Target 12/13: 100% Target 13/14: 100%

Indicator: C-Difficile (Reported Monthly)



	Actual	Target
13-Q1	0.80	**0.33**
13-Q2	0.39	**0.33**
13-Q3	0.81	**0.33**
13-Q4	0.72	**0.34**
14-Q1	0.65	**0.34**

Interpretation - Patient And Business:

Values are monthly - Feb '13 - June '13

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans

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

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

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

Target: Target 09/10: 0.26 Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better Target 12/13: PAOB Target 13/14: PAOB Perf. Corridor: Red > 10% Prov. Rate Yellow Within 10% Prov. Rate Green <= Prov. Rate

Kingston General Hospital

MS #02

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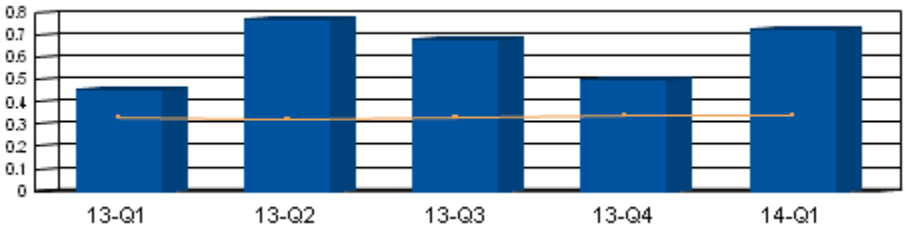
The top sources of preventable harm to patients are addressed

Indicator: C-Difficile (Reported Quarterly)



	Actual	Target
13-Q1	0.46	**0.33**
13-Q2	0.77	**0.32**
13-Q3	0.68	**0.33**
13-Q4	0.50	**0.34**
14-Q1	0.73	**0.34**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.73 cases per 1000 patient days; an increase from the last quarter of 2012- 2013. In April 10 cases of CDI. In May, we had 9 cases and in June there were 8 cases giving us a total of 27 cases for the quarter; in comparison to quarter 4, where we had 20 cases. It is worth noting that as of May 1, 2013, we have not experienced an outbreak of CDI for a period of one year.

Actions & Monitoring Underway to Improve Performance:

KGH has not had a CDI outbreak declared since Q4 F 11/12, the longest duration in last 5 years. IPAC redesign and leadership has been a key component in this success along with the new ASP.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans

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, Target 13/14: 0.37 Perf. Corridor: Red >0.35 Yellow 0.30-0.35 Green <=0.30

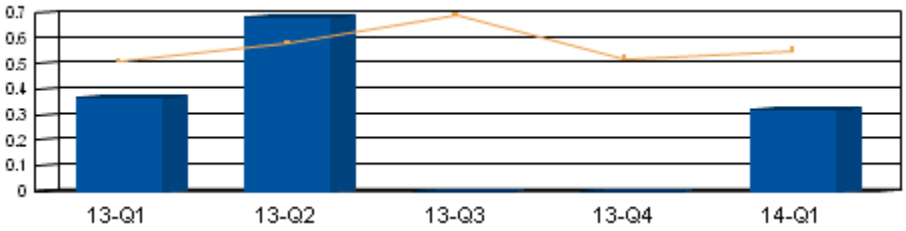
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Central Line Bloodstream Infections



	Actual	Target
13-Q1	0.37	**0.51**
13-Q2	0.68	**0.58**
13-Q3	0.00	**0.69**
13-Q4	0.00	**0.52**
14-Q1	0.32	**0.55**

Interpretation - Patient And Business:

Continues to stay below performance target with some peaks on a monthly basis due to small denominators.

Actions & Monitoring Underway to Improve Performance:

Continue to monitor and ensure compliance with CLI bundle, particularly since the insertion kit is under review from an OE point of view.

Definition: DATA: CCIS COMMENTS: Mae Squires

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 Perf. Corridor: Red > 10% Prov. Rate Yellow Within 10% Prov. Rate Green <= Prov. Rate

Kingston General Hospital

MS #02

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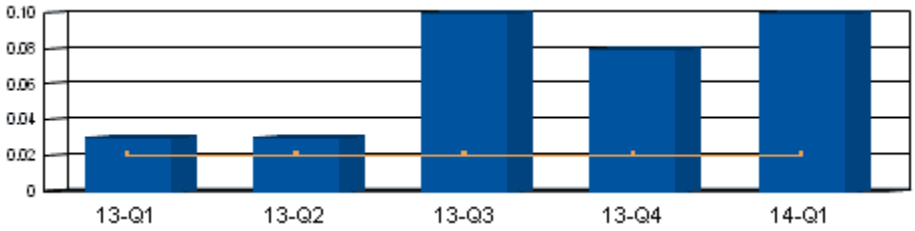
Indicator: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
13-Q1	0.03	**0.02**
13-Q2	0.03	**0.02**
13-Q3	0.10	**0.02**
13-Q4	0.08	**0.02**
14-Q1	0.10	**0.02**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.1 per 1000 patient days which represents 4 cases. Both cases in April were newly positive for MRSA, however both the case in May and in June occurred in patients who were known to be colonized for MRSA prior to developing the bacteremia.

Actions & Monitoring Underway to Improve Performance:

Further reinforcement of Admission Screening protocol in concert with hand hygiene and IPAC standards will be paramount to ensure MRSA is being identified on admission and patients are placed on appropriate precautions.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans

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, Target 13/14: Perf. Corridor: PAOB Red > 10% Prov. Rate Yellow Within 10% Prov. Rate Green <= Prov. Rate

Kingston General Hospital

MS #02

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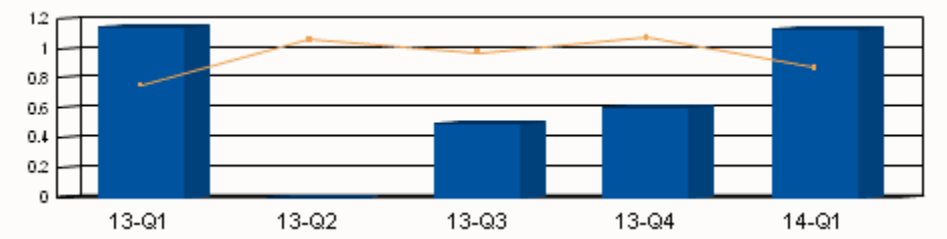
The top sources of preventable harm to patients are addressed

Indicator: Ventilator Associated Pneumonia



	Actual	Target
13-Q1	1.14	**0.75**
13-Q2	0.00	**1.06**
13-Q3	0.50	**0.97**
13-Q4	0.60	**1.07**
14-Q1	1.13	**0.87**

Interpretation - Patient And Business:

Rate slightly above target but related to a decrease in ventilator days reducing the denominator and increasing the impact of those two cases that were documented to have VAP this quarter.

Actions & Monitoring Underway to Improve Performance:

If ventilator days would not have decrease, the rate likely would have been within current expected norm. Continue to monitor closely to ensure a trend has not developed.

Definition: DATA: CCIS COMMENTS: Mae Squires

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, Target 13/14: PAOB Perf. Corridor: Red >10% Prov. Rate Yellow Within 10% Prov. Rate Green <= Prov. Rate

Kingston General Hospital

MS #02

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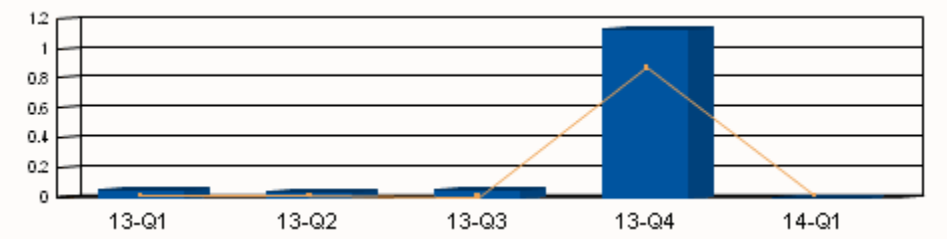
Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
13-Q1	0.05	**0.01**
13-Q2	0.03	**0.01**
13-Q3	0.05	**0.00**
13-Q4	1.13	**0.87**
14-Q1	0.00	**0.01**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0. We have now achieved six months with no VRE bactermias. June 25th, 2013 marked one year since we discontinued placing patients with VRE on precautions. Surveillance of all VRE infections continues.

Business Perspective: KGH IPAC continues to survey and collect data on VRE infections but not colonization. All clinical isolates are reviewed to determine clinical relevance. 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 since July 2012 concurrently with TOH, UHN and LHSC.

Definition: DATA: Infection Control COMMENTS: Dr.Gerald Evans

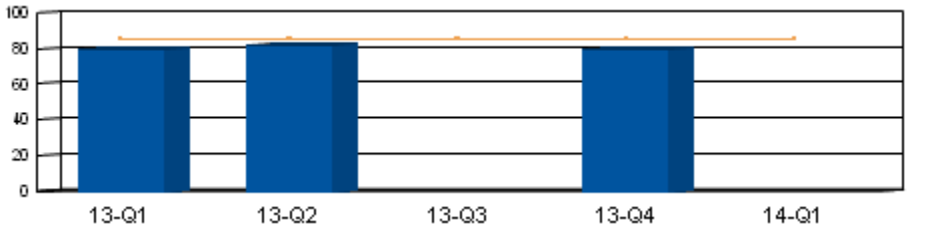
Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. If a person has an infection caused by VRE, such as a blood infection, 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 Perf. Corridor: Red >10% Prov. Rate Yellow Within 10% Prov. Rate Green <= Prov. Rate

Indicator: External Environmental Audits by Westech



	Actual	Target
13-Q1	80	**85**
13-Q2	82	**85**
13-Q3		**85**
13-Q4	79	**85**
14-Q1		**85**

Interpretation - Patient And Business:

Westech has not completed an audit for Q1 of 13/14.

Definition: DATA: Jim Jeroy COMMENTS: Dr.David Zelt

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% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

Kingston General Hospital

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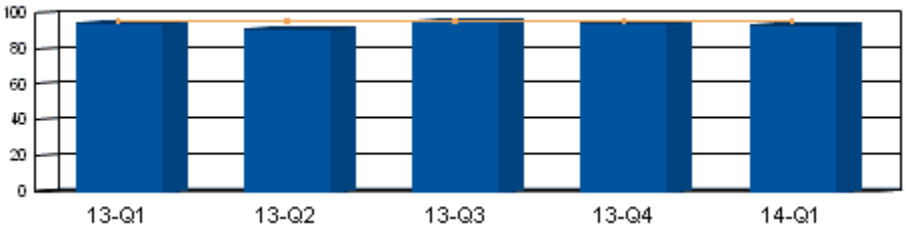
The top sources of preventable harm to patients are addressed

Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
13-Q1	94	**95**
13-Q2	91	**95**
13-Q3	95	**95**
13-Q4	94	**95**
14-Q1	93	**95**

Interpretation - Patient And Business:

Patient Perspective: In April, May and June hand hygiene auditors continued to receive IPAC support and instruction to enhance their auditing techniques so data is accurately captured. 2013- 2014 IPAC will continue their work with auditor to increase the number of opportunities observed. At the end of fiscal 2012 - 2013 all education sessions with HH content were updated and the LMS module on Hand Hygiene was finished in collaboration with People Services. KGH as an organization continues to maintain its focus on HH understanding the importance this action plays in reducing the transmission of nosocomial infections overall.

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: DATA: Decision Support (Handy Audit) COMMENTS: Dr.Gerald Evans

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%, Target 13/14: 98% Perf. Corridor: Red <90% Yellow 90%-97% Green >=98%

Kingston General Hospital

MS #02

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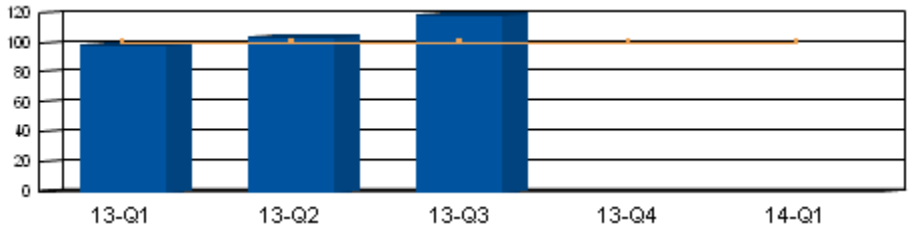
Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
13-Q1	98	**100**
13-Q2	103	**100**
13-Q3	119	**100**
13-Q4		**100**
14-Q1		**100**

Interpretation - Patient And Business:

Actions & Monitoring Underway to Improve Performance:

Definition: DATA: Decision Support COMMENTS: Dr.David Zelt

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, Target 13/14: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

Indicator: Percent of Recommendations Completed as per Critical Incident Review Triggered by Mortality Within 5 Days of Major Surgery - (QIP)

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

Interpretation - Patient And Business:

A new indicator. Development of processes to identify deaths within five days of major surgery is underway with Decision Support and Medical Records. Deaths will be reviewed by the respective Surgical Divisions and presented to JQUIC/MAC.

Definition: COMMENTS: Dr. David Zelt

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 takes 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 13/14: 100% Perf. Corridor: Red <70% Yellow 70%-90% Green >=90%

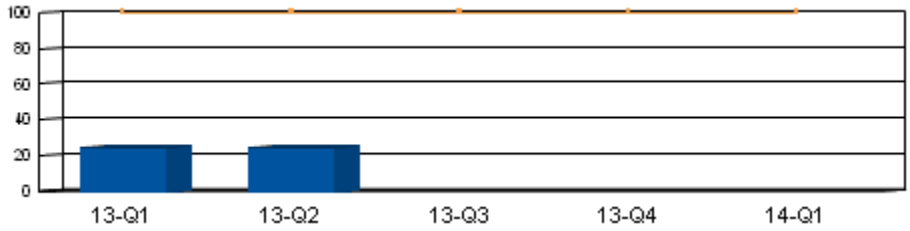
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Percent Mortality Reviews Completed with Review of Record Level HSMR Data - (QIP)



	Actual	Target
13-Q1	24	**100**
13-Q2	24	**100**
13-Q3		**100**
13-Q4		**100**
14-Q1		**100**

Interpretation - Patient And Business:

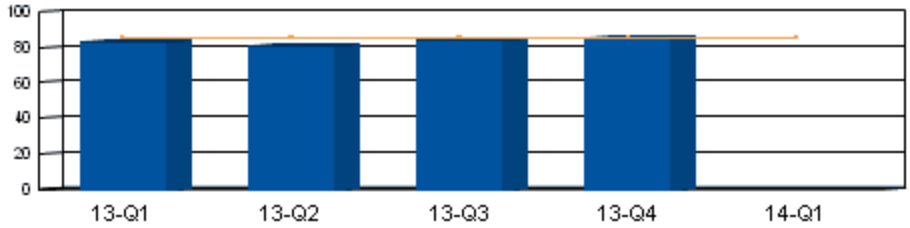
Actions & Monitoring Underway to Improve Performance:

Definition: DATA: Decision Support COMMENTS: Dr.David Zelt

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%, Target 13/14: 100% Perf. Corridor: Red <80% Yellow 80%-90% Green >90%

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



	Actual	Target
13-Q1	83	**85**
13-Q2	81	**85**
13-Q3	84	**85**
13-Q4	85	**85**
14-Q1		**85**

Definition: DATA: Astrid Strong Comments: Jim Jeroy

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

Target: Target 2012/13: 85%, Target 13/14: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

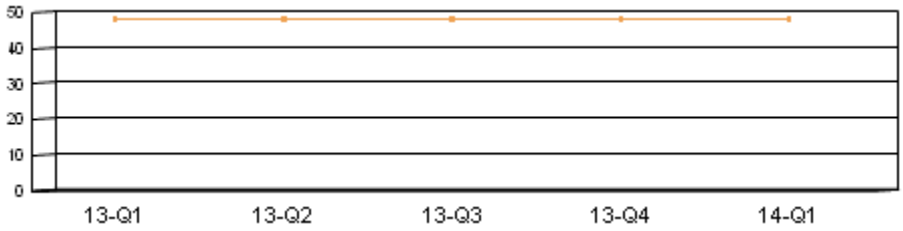
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

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



	Actual	Target
13-Q1		48
13-Q2		48
13-Q3		48
13-Q4		48
14-Q1		48

Interpretation - Patient And Business:

No update. Patient Safety Culture survey will be administered again Fall 2013.

Definition: DATA: Astrid Strong COMMENTS: Dr.David Zelt

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.

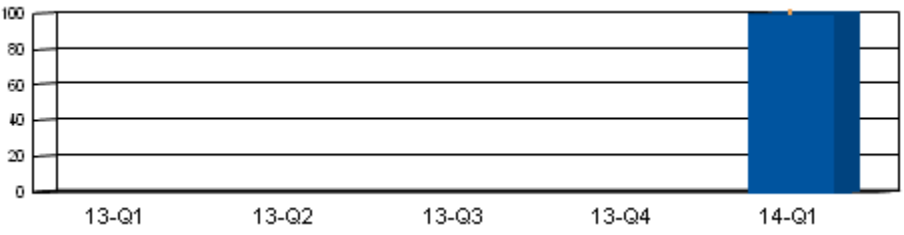
The Patient Safety Culture Tool includes 40 items (plus demographic items). Two items assign an overall patient safety grade of the unit and the organization. The remaining 38 items measure the following dimensions:
• Senior leadership support for safety
• Supervisory leadership support for safety
• 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%, Target 13/14: 48% Perf. Corridor: Red <28% Yellow 29%-47% Green >=48%

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



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	100	100

Interpretation - Patient And Business:

100% of resulting Quality of Care Review recommendations have been considered and are being currently acted upon in some capacity. There were three (3) critical care investigations/quality of care reviews completed from April to June concerning treatment/care issues.

Definition: COMMENTS: Eleanor Rivoire

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 13/14: 100% Perf. Corridor: Red <70% Yellow 70%-80% Green >80%

The top sources of GRIDLOCK are addressed

Yellow

Strategic Direction	KGH 2015 outcome	Indicator
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	Percent of recommendations completed as per incident review triggered by code GRIDLOCK

Improvement Priorities	
Reduce wait times	Decrease avoidable admissions
Reduce length of stay	Optimize occupancy rates

1. **What is our actual performance on the indicator for this milestone as listed above?** A corporate VSM process was launched in May with over 60 interprofessional and support service staff members meeting on 3 occasions. The flow of patients presenting to Emergency, admitted to inpatient beds and through to discharge has been described. More detailed assessment of steps in this process occurred with clinical teams resulting in 10 opportunities being identified as continuous improvement opportunities between the point of presentation to ED and admission to the inpatient unit. The Patient Flow Task Force agreed upon 5 to proceed as first priorities. Project teams have been struck and are currently working on 90-120 day PDSA improvement cycles. Arrangements have been put in place to complete a similar process in August for the later part of patient flow (from unit to discharge).
In Q1 there have been 5 Gridlocks which is up relative to Q1 2013 (n=1) and down relative to Q4 2013 (n=7). With each Gridlock, there is review by the Patient Flow Task Force (PFTF) to determine what factors are deemed to have contributed to the Gridlock, and to ensure they are captured and considered relative to the opportunities identified within the Gridlock VSM process.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** The five priorities being worked on at this time are focused on the processes for decision to admit; for accurate and timely data going to bed allocators; for bed status notification, for handover of patient information from ED to inpatient unit and for having an accurate on-call schedule. All are proceeding with the expectation of a 90-120 day cycle which would target trial of improved process and readiness for further roll out by end of September.

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

4. **What new tactics are planned to ensure this milestone is met?** The Patient Flow Task Force, as the corporate committee that oversees the Gridlock initiative, meets every two weeks with updates on the Gridlock VSM initiative and with the PDSA improvement teams. By end of August, there will be additional CI opportunities identified by the Gridlock VSM group for the patient flow from the inpatient unit to time of discharge, and together with those already identified, will serve as the list to guide activities for the remaining year. Additionally work is being done to influence the supporting indicators. Review of occupancy rates relative to planned activity has been initiated and the indicator continues to be refined. Preliminary data suggests opportunity for bed map redesign to support areas with high occupancies by realigning beds and potentially relocating services. As well, a focused review of lengths of stay for less than 48 hours has been initiated to determine what opportunities might exist to avoid short duration admissions. Programs will become engaged in Q2. .

Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

	13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	R	Y	Y	R	R	↓
Percent of Recommendations Completed as per Incident Review Triggered by Code GRIDLOCK - (QIP)	N/A	N/A	N/A	N/A	Y	
Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	R	Y	Y	Y	R	↓
All Cancer Surgery Wait Time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)	R	R	R	R	R	↑
Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met	R	R	R	R	R	↑
Radiation Wait time (Referral-Consult) Percent Seen Within 14 Days	R	R	R	R	R	↓
Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets	R	Y	Y	Y	R	↓
All Paediatric Surgery - 90th Percentile Wait Time (Days)	G	Y	G	G	G	↑
Cardiac - Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
Cardiac - Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
Cardiac - Coronary Angioplasty - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
Orthopedic Surgery (Excluding Total Hip and Knee Replacements) - 90th Percentile Wait Time (Days)	R	Y	Y	Y	R	↓
Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)	G	G	G	G	G	↑

25	13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Diagnostic Imaging- MRI – 90th Percentile Wait Time (Days)	R	R	R	R	R	↑
Average # ALC Patients per Day	R	R	R	R	R	↑
Percent ALC Days	G	G	G	G	R	↓
Overall - Acute Average Length of Stay Days (Based on HSAA)	G	G	Y	G	G	↑
Overall - Acute Average Length of Stay vs ELOS Variance in Days	Y	Y	G	Y	G	↑
Percent of Clinical Services Meeting or Exceeding ELOS Target	R	R	R	R	Y	↑
Number of Inpatient by Program Floor Assignment Patient Days Within Budget	N/A	N/A	N/A	N/A	Y	
Reduce the Number of Avoidable Admsisions	N/A	N/A	N/A	N/A	R	
Total Inpatient Admissions	G	G	G	G	G	↑
Total Inpatient Weighted Cases	G	G	G	G	G	↑
90th Percentile ED Wait Time - All Admitted Patients (Hrs) - QIP	Y	R	R	R	R	↑
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs	G	Y	Y	Y	Y	↑
Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↓
Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	Y	R	R	R	R	↑
Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	G	Y	G	G	G	↑
Non-Admitted Patients with Minor or Uncomplicated Conditions in the Emergency Department (ED) - 90th Percentile Wait Time (Hrs)	R	R	R	R	R	↑
Percent of Wait Time Contracted Volumes Achieved	R	R	R	R	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

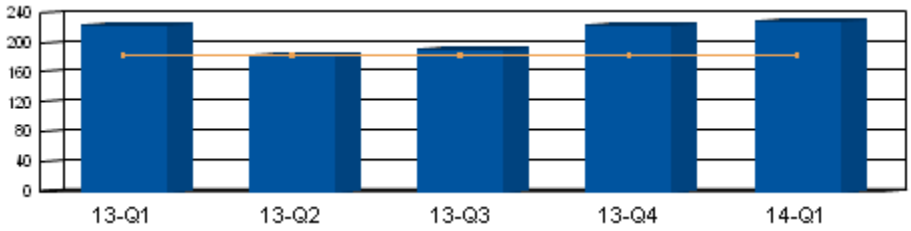
Kingston General Hospital

MS #03

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

The top sources of preventable harm to patients are addressed

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



	Actual	Target
13-Q1	223	**182**
13-Q2	183	**182**
13-Q3	192	**182**
13-Q4	224	**182**
14-Q1	229	**182**

Interpretation - Patient And Business:

For Q1 there were 222 completed cases with median wait times for this quarter decreasing from 92 days in April to 55 days in June. There were 41 surgeries cancelled in this quarter for the following reasons; change in patients' medical condition (5), gridlock (9).emergency case substitution (3), no available bed (9), unexpected case complication from previous case (9), insufficient time (2), provider illness (2), and patient unavailable (1).

Currently there are 332 general surgery (non cancer) cases on the waiting list with 52 cases averaging a wait time of 205-1348 days.

Actions & Monitoring Underway to Improve Performance:

The SPA program continues to support for this service additional OR time during the evening and on weekends to add any elective cases once the trauma cases are addressed to assist with reducing long wait time cases. The Program is working with the service by supporting additional monitoring resources for wait time lists.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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, Target 13/14: 182 Days
Perf. Corridor: Red >200 Yellow 183-200 Green <=182

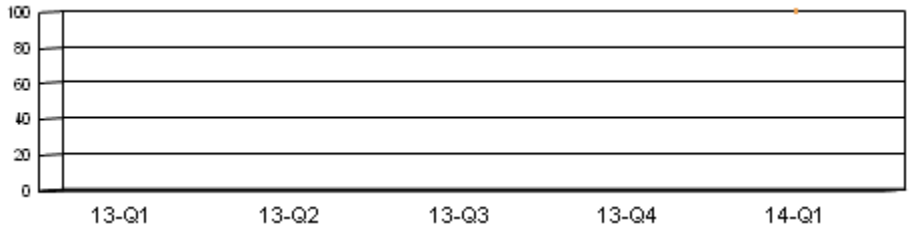
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Percent of Recommendations Completed as per Incident Review Triggered by Code GRIDLOCK - (QIP)



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1		100

Interpretation - Patient And Business:

In Q1 there have been 5 Gridlocks which is up relative to Q1 2013 (n=1) and down relative to Q4 2013 (n=7). A corporate VSM process was launched in May and involved over 60 interprofessional/support service staff members meeting on 3 occasions. The flow of patients from Emergency to inpatient beds through to discharged was described, and following more detailed work with clinical teams 10 opportunities were identified as continuous improvement opportunities for processes between presentation of patients to ED and transfer to inpatient unit. 5 were agreed upon as first priorities. Project teams have been struck and are currently working on 90-120 day PDSA improvement cycles.

With each Gridlock, there is review by the Patient Flow Task Force (PFTF) to determine what factors are deemed to have contributed to the Gridlock, and to ensure they are considered and captured as factors within the Gridlock VSM process.

Actions & Monitoring Underway to Improve Performance:

Work is proceeding to plan. The Patient Flow Task Force, as the corporate committee that oversees the Gridlock initiative, meets every two weeks with updates on the Gridlock VSM initiative and with the PDSA improvement teams. By end of August, there will be additional CI opportunities identified by the Gridlock VSM group for the patient flow from the inpatient unit to time of discharge, and together with those already identified, will serve as the list to guide activities for the remaining year.

Definition: COMMENTS: Eleanor Rivoire

Gridlock is a state of total congestion where patient needs (inputs) far outweigh available bed capacity combined with an inability to move patients in the necessary timeframes. Hospital-wide gridlock will typically but not necessarily require all of the following criteria to be met.
1. Critical Care: >6 critically ill patients in PACU, ED, OR or other locations where critically ill patients are not typically cared for, with no possibility of discharges due to ICU patient acuity (115% critical care bed resource)
2. Emergency Department: >15 admitted patients with no possibility of hallway transfer or with no identified inpatient beds in the next 4 hours.
3. Inpatient Units: 1 inpatient in all 10 hallways (C9/10; K 3/4/5/6/7/9; D3/5) – or equivalent if any area having more than 1 overcapacity patient.
The purpose of the Incident review process is to assess and evaluate provision / process of health care resulting from gridlock issues with a view to improving or maintaining the quality of healthcare. The review team makes recommendations to prevent recurrence and assigns esponsibility for implementation consideration of each recommendation. In addition, that there are fully implemented processes and reporting through the Patient Flow Task Force and Executive sponsors as it relates to continuous improvement cycles.

Target: Target 13/14: 100% Perf. Corridor: Red <70% Yellow 70%-80% Green >80%

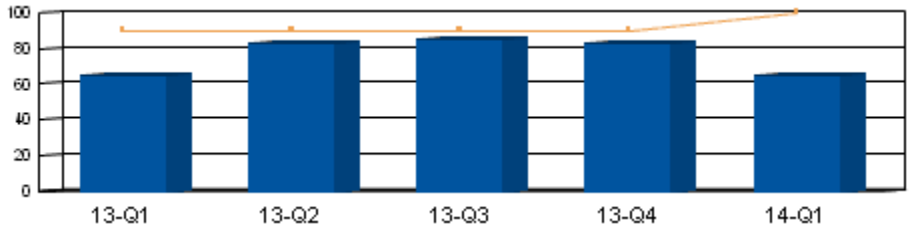
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	65	**90**
13-Q2	83	**90**
13-Q3	85	**90**
13-Q4	83	**90**
14-Q1	65	**100**

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:

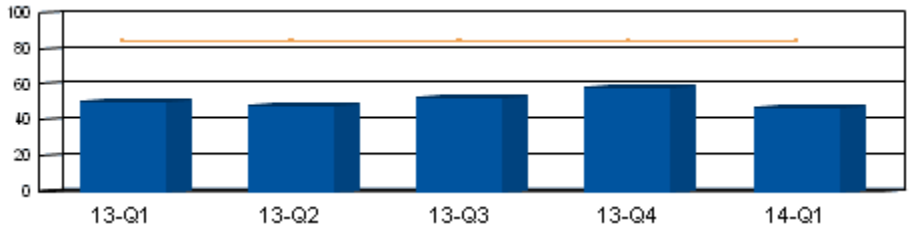
A significant decrease in services meeting the 90th percentile wait time target has occurred in Q1. There has been an increase from 9 to 18 services not meeting the target (4 general surgery; 4 gynecology; 2 orthopedic; 3 Plastic surgery; 4 urology;1MRI). The Wait Time Initiative Committee will review the current change and focus on sustainability of initiatives that lead to the improvements Q1 to Q4 in the last fiscal reporting period.

Definition: COMMENTS: John Lott

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%, Target 13/14: 100% Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

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



	Actual	Target
13-Q1	50	**84**
13-Q2	48	**84**
13-Q3	52	**84**
13-Q4	58	**84**
14-Q1	47	**84**

Interpretation - Patient And Business:

For Q1, the 90th percentile wait time is better than the provincial target in days waiting. Although there was increased unpredictable patient activity (gridlocks), protocol was strictly adhered to ensuring that cancer cases were given top priority along with trauma cases for completion. Additional enhanced OR time dedicated to this service as well as priority level management by the oncology program continues to contribute to the ongoing "green" of this indicator.

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: DATA: Decision Support COMMENTS: Kellie Kitchen

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, Target 13/14: 84 days Perf. Corridor: Red >92 Yellow 85-92 Green <=84

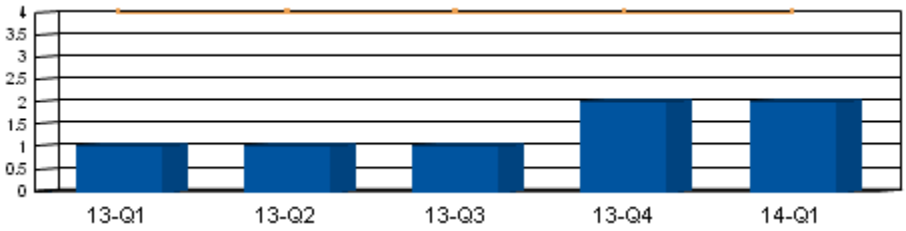
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



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

Interpretation - Patient And Business:

At the end of Q1 F14, KGH is not meeting this indicator. 2 of the 4 indicators met the CCO contracted access to care indicator target. KGH continues to meet the radiation consultation to start of radiation treatment indicator (Q1 F14 performance is 100%) and Systemic referral to consult indicator (Q1 F14 performance is 70% vs. 67% in Q4 F13). While systemic consult to referral indicator is not meeting target as of Q1, there has been an improvement since Q4 F13 (64% Q4 F13 vs. 70% Q1 F14).

Specifically, the indicators included in this group are wait time from:

- radiation referral to a radiation oncologist to consultation (target is 80% of all referrals to a radiation oncologist are seen within 14 days)
- radiation ready-to-treat date to start of radiation treatment (target is 87% of all patients who will receive radiation treatment start their treatment within target for all priority categories (1, 7, or 14 days)
- systemic referral to a medical oncologist to consultation (target is 67% of all referrals to a medical oncologist are seen within 14 days)
- systemic consultation to start of chemotherapy treatment (target is 85% of all patients who will receive radiation treatment start their treatment in 14 days)

Actions & Monitoring Underway to Improve Performance:

Access to care indicators are closely monitored as part of the KGH and Cancer Care Ontario performance scorecards and quarterly review processes. MRPs within the cancer program have been assigned responsibility to monitor and review this data with their respective committees on a monthly basis.

Formal improvement initiatives were launched in F13 to address data quality, capacity, process or accountability issues impacting on KGH's ability to meet these access targets. Oncologist vacancies in both Radiation and Medical Oncology are contributing to the challenge in meeting these wait time targets. A new 0.6 radiation oncologist joined the team in July 2013 and a new 1.0 medical oncologist will join mid-September 2013. This should help move KGH closer to meeting the access targets in F14.

Cancer Program clinical and operational leaders are overseeing these initiatives and will be reporting on progress through KGH's and CCO's Quarterly Review mechanism as well as through the Q&S plan for the Cancer Program.

Definition: DATA: Decision Support - Cancer COMMENTS: Brenda Carter

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 12/13: 4 Target 13/14: 4 Perf. Corridor: Red <3 Yellow 3 Green 4

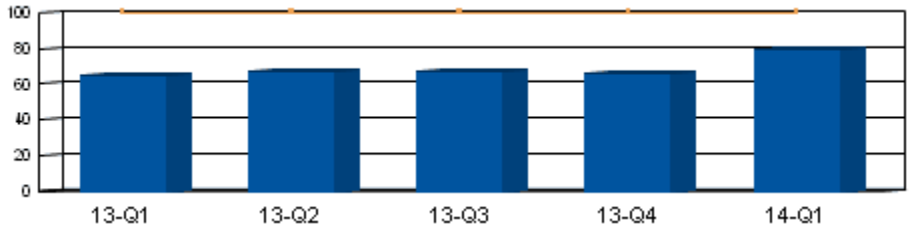
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	65	**100**
13-Q2	67	**100**
13-Q3	67	**100**
13-Q4	66	**100**
14-Q1	79	**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 Q1 F14, KGH is not meeting this target. However, performance improvement is evident compared to Q4 F13 results. 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:

At end of Q1, KGH did not meet the Cancer Care Ontario Cancer Surgery contracted target, however, marked improvement has occurred in Q1 F14 compared to Q4 F13. Specifically, the % of cancer surgery cases completed within the identified priority code increased from 66.1% in Q4 F13 to 79% in Q1 F14. CCO target in this indicator is 90% of cases meeting wait time target. Only 4 out of 14 LHINs are at or above 90%.

Month over month improvement in KGH/HDH performance was seen during Q1. The Cancer Surgery Wait Time Improvement Team continues to be very active in its efforts to sustain the gains as well as push further toward the 90% target.

Pro-active wait list management remains in place. All surgical oncology wait lists are reviewed 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% in May 2012 to as low as 3% in July 2013.

Quality assurance of priority assignments continues and has positively impacted the assignment of priority codes by the surgeons to allow KGH to align with the provincial standards.

Work is also underway between SPA leaders and Cancer Program leaders to determine how assignment of "booked" OR time for cancer surgery can be improved to allow more cases to get to the OR within the priority time assigned. This work is essential for reaching the 90% target.

Definition: DATA: Lyndsay Richardson COMMENTS: Brenda Carter

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 12/13: 100% Target 13/14: 100% Perf. Corridor: Red <80% Yellow 80%-89% Green >=90%

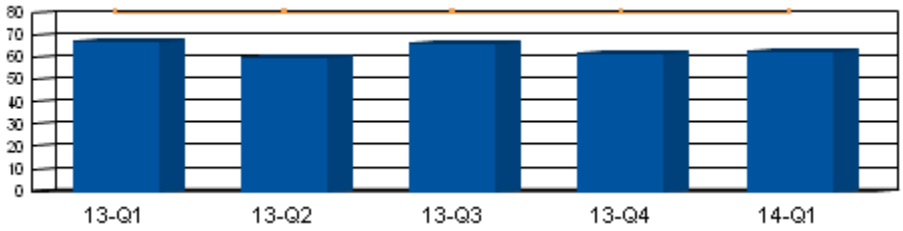
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	67	**80**
13-Q2	60	**80**
13-Q3	66	**80**
13-Q4	62	**80**
14-Q1	63	**80**

Interpretation - Patient And Business:

The time between a referral to see a radiation oncologist and the time the patient is seen is a key access indicator for CCO. The 13/14 target for this indicator is 80% of all patients referred to a radiation oncologist are seen within 14 days.

As of Q1 F14, only 63% of all patients referred to KGH are seen by a radiation oncologist within 14 days.

Actions & Monitoring Underway to Improve Performance:

A focused review of breast cancer referrals has been completed and a number of improvement opportunities have been identified. These will be presented to the Breast Disease Site Team in early September for endorsement and action.

Reasons for under-performance include radiation oncology vacancies (1.0 ftes as of end of March 2013), process delays, booking/scheduling practices, early referral of post-surgical patients, incomplete information from referring source, and data quality. Referrals for patients requiring combined modality treatment also negatively impact wait times. Improving this performance is high priority and sponsored by the RVP and PMD and is also on the QIP for the Cancer Program in F14.

A new 0.6 radiation oncologist joined the Cancer Program team in July 2013. This should help improve the wait time from referral to consult.

Definition: DATA: Lyndsay Richardson COMMENTS: Brenda Carter
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%, Target 13/14: 80% Perf. Corridor: Red <72% Yellow 72%-79% Green >80%

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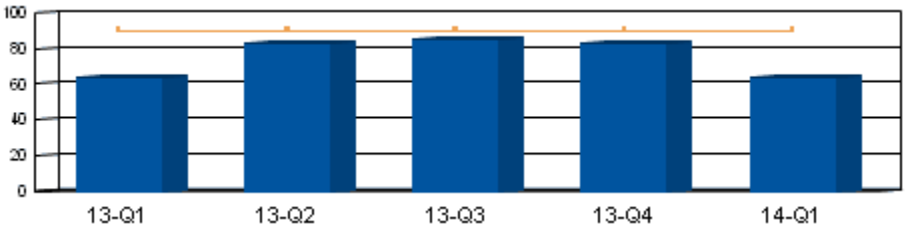
Indicator: Percent of Total Surgical Wait Times Meeting or Exceeding 90th Percentile Wait Time Targets



	Actual	Target
13-Q1	64	**90**
13-Q2	83	**90**
13-Q3	85	**90**
13-Q4	83	**90**
14-Q1	64	**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:

A significant decrease in services meeting the 90th percentile wait time target has occurred in Q1. There has been an increase from 8 to 17 services not meeting the target (4 general surgery; 4 gynecology; 2 orthopedic; 3 Plastic surgery; 4 urology). The Wait Time Initiative Committee will review the current change and focus on sustainability of initiatives that lead to the improvements Q1 to Q4 in the last fiscal reporting period.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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%, Target 13/14: 90% Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

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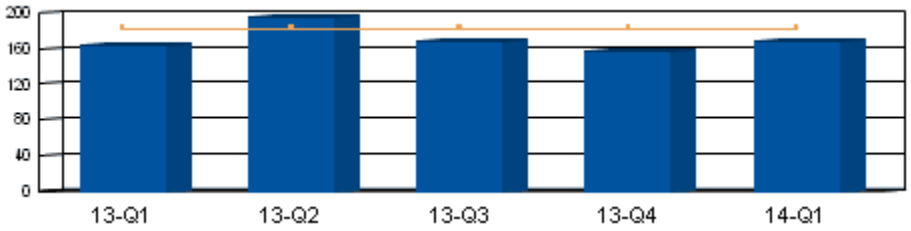
Indicator: All Paediatric Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
13-Q1	164	**182**
13-Q2	195	**182**
13-Q3	167	**182**
13-Q4	157	**182**
14-Q1	167	**182**

Interpretation - Patient And Business:

Improved monitoring of office wait times along with access to general emergency OR time has contributed to this indicator achieving its target. The breakdown of pediatric service activity is as follows:

General Surgery (1 case):
There was only one pediatric patient who was done in this quarter who was on the waiting list for 235 days.

Orthopedics (5 cases)
90% percentile was 90 days for this quarter with a median wait of 49 days. There are currently 21 pediatric patients on the waiting list with 13 having already waited greater than 182 days.

Urology (8 cases)
90% percentile was 211 days this quarter with an average median wait of 211 days. Influencing these days was the completion of 4 cases ranging from wait times of 239 days to 506 days. There were 10 cancelled pediatric cases this quarter due to patient change in condition, patient unavailability, and previous case complication overlapping into next patient's time.

ENT
There 18 pediatric patients who received their surgery within the 182 days or less with only two patients who exceed this time with a wait time of 195 and 404 days respectively. There were 2 patients for this service that were cancelled due to previous case complications that overlapped into their scheduled time.

Actions & Monitoring Underway to Improve Performance:

Monitoring of this indicator continues to be provided by the Wait Time Committee and SPA program council.

The recruitment for an 0.5FTE pediatric general surgery is underway.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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 Perf. Corridor: Red >200 Yellow 183-200 Green <=182

Kingston General Hospital

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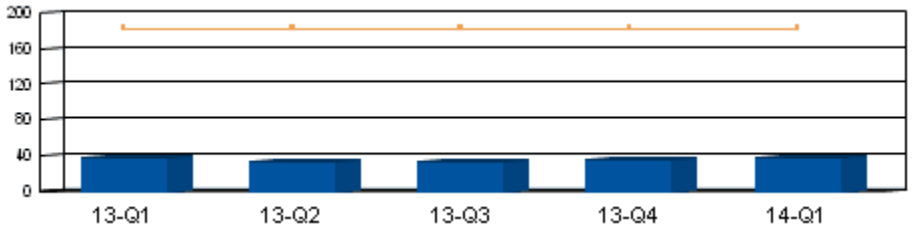
The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	37	**182**
13-Q2	33	**182**
13-Q3	33	**182**
13-Q4	35	**182**
14-Q1	37	**182**

Interpretation - Patient And Business:

Based on Q1 activity, KGH is meeting the performance target for elective cardiac bypass surgery wait times. Wait time at the 90th percentile is 37 days which is 53 days below the provincial target of 90 days for elective CABG. 100% of all elective cases were completed within the recommended maximum wait time of 90 days. Patients are not waiting beyond the RMWT for cardiac bypass surgery at KGH.

Actions & Monitoring Underway to Improve Performance:

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

Definition: DATA: Katelyn Balchin COMMENTS: Julie Caffin

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, Target 13/14: 182 days
Perf. Corridor: Red >200 Yellow 183-200 Green <=182

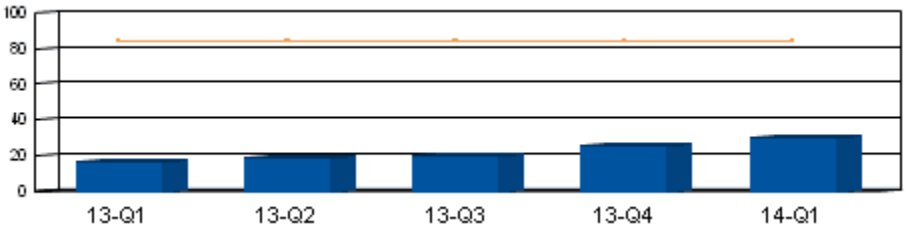
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	17	**84**
13-Q2	19	**84**
13-Q3	20	**84**
13-Q4	26	**84**
14-Q1	30	**84**

Interpretation - Patient And Business:

Based on Q1 activity, KGH is meeting wait time target for cardiac angiography. Wait time for elective angiography is 30 days at the 90th percentile. This is 54 days below the provincial target. 100% of patients had their elective angiogram within the recommended wait time.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac catheterization monitors wait lists daily and books patients according to urgency rating. All patients in the region are booked for procedures based on this urgency rating.
Close attention is paid to ensuring we are serving the regional hospitals and patients across the LHIN in an equitable manner. This is achieved in part through the same day program and the STEMI By-pass protocol.

Definition: DATA: Katelyn Balchin COMMENTS: Julie Caffin

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 Perf. Corridor: Red >92 Yellow 85-92 Green <=84

Kingston General Hospital

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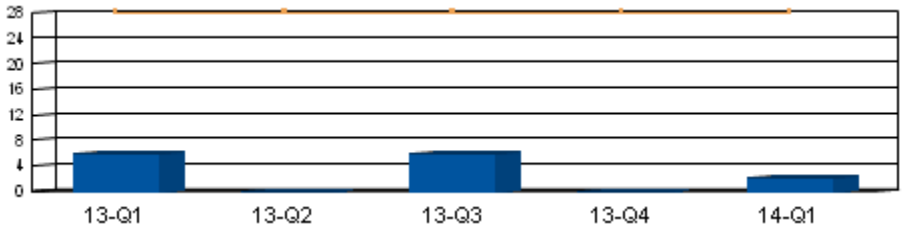
Transform the patient experience through a relentless focus on quality, safety and service

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	6	**28**
13-Q2	0	**28**
13-Q3	6	**28**
13-Q4	0	**28**
14-Q1	2	**28**

Interpretation - Patient And Business:

Based on Q1 activity, KGH is meeting the wait time target for coronary angioplasty. The wait time at the 90th percentile is 2 days which is 26 days below the provincial target. The median for elective PCI in Q1 averages 2 days. 100% of all patients are completed with the recommended wait time for elective and semi-urgent angioplasties. Urgent angioplasty volumes are very low since the majority of urgent patients are done at the same time as their angiography.

Actions & Monitoring Underway to Improve Performance:

A Regional Cardiac Care Coordinator (RCCC) dedicated to cardiac catheterization monitors wait lists daily and books patients according to urgency rating. Many angioplasties occur as same sitting PCI which means diagnostic angiograms are followed by angioplasty in one procedure. The number of same sitting PCIs done at KGH is just at the provincial average. This results in one lab time for the patient rather than 2 separate procedures booked at 2 different times.
No concerns as wait times are well under target.

Definition: DATA: Katelyn Balchin COMMENTS: Julie Caffin

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, Target 13/14: 28 Days Perf. Corridor: Red >32 Yellow 29-32 Green <=28

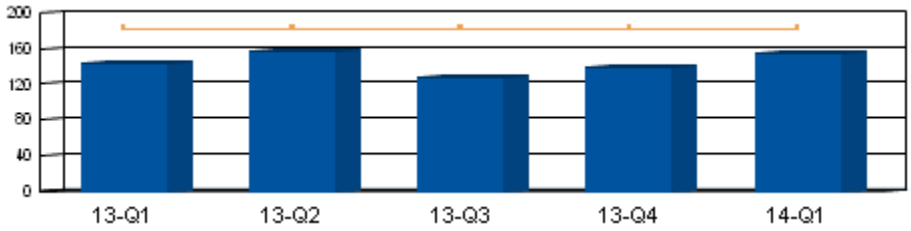
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	144	**182**
13-Q2	156	**182**
13-Q3	127	**182**
13-Q4	139	**182**
14-Q1	154	**182**

Interpretation - Patient And Business:

For Q1 this indicator is still well below target although there was a slight increase in wait times of 15 days from last fourth quarter. There were 101 completed cases with median wait times starting at 52 days in April increasing to 91 days in June. In this time period there were 18 cancelled surgery cases due to Gridlock (6), no available bed (8) along with 4 cases for other reasons (emergency case cancellation, patient no show, improper booking, and broken equipment.

There are currently 203 patients on the wait list with 13 having waited more than the 182 day target.

Actions & Monitoring Underway to Improve Performance:

Constant monitoring of wait times are being conducted by program management and the Wait Time committee.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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, Target 13/14: 182
Perf. Corridor Red >200 Yellow 183-200 Green <=182

Kingston General Hospital

MS #03

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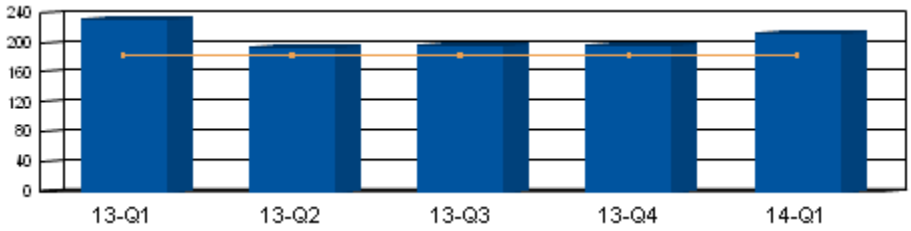
The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	232	**182**
13-Q2	193	**182**
13-Q3	197	**182**
13-Q4	196	**182**
14-Q1	212	**182**

Interpretation - Patient And Business:

For Q1 there continues to be a slight increase in wait times. There were 179 completed cases with median wait times starting at 79 days in April decreasing to 46 days in June. In this time period there were 20 cancelled surgery cases due to Gridlock (4), no available bed (6) along with 4 cases for other reasons (1 emergency case cancellation, 1 insufficient OR time remaining.1 improper booking, 1 2 patient no show and 5 unexpected surgical complications from the previous case that overlapped into the next patients OR time).

There are currently 236 patients on the wait list with 45 having waited more than the 182 day target.

Actions & Monitoring Underway to Improve Performance:

Constant monitoring of wait times is being conducted by program management and the Wait Time committee.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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, Target 13/14: 182 days Perf. Corridor: Red >200 Yellow 183-200 Green <=182

Kingston General Hospital

MS #03

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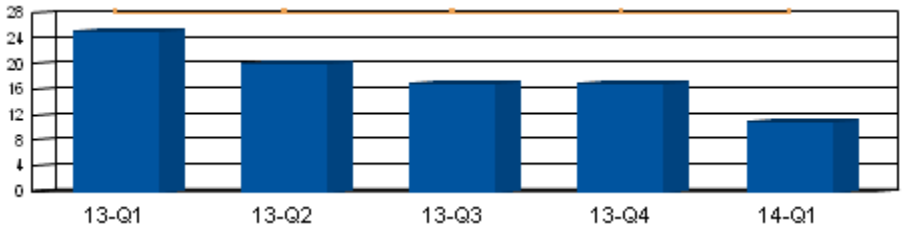
The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	25	**28**
13-Q2	20	**28**
13-Q3	17	**28**
13-Q4	17	**28**
14-Q1	11	**28**

Interpretation - Patient And Business:

The LHIN set a very aggressive target for KGH during Fiscal 2012/2013 of 15 days. The department focused its efforts on ensuring that bookings were maximized and that booking information was being inputted properly. KGH's environment primarily deals with P1 and P2 cases and timed examinations. Considering this is our primary patient population the wait time should be very low. ER, Inpatient, and urgent OP exams are required in a short time frame as the physicians "decision to treat" often depends on the CT results. Meeting the Cancer Center "timed" exam booking requests are critical to these patients' population "Journey of Care". So even though we are well below the provincial target and even succeeded in being below the LHIN target we must not lose focus and allow our wait times to creep up. Maintaining low CT wait times is critical to supporting many services within the hospital.

Actions & Monitoring Underway to Improve Performance:

Continue to monitor and maintain low wait time.

Definition: DATA: Decision Support COMMENTS: Karen Pearson

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, Target 13/14: 28 Days Perf. Corridor:Red >32 Yellow 29-32 Green <=28

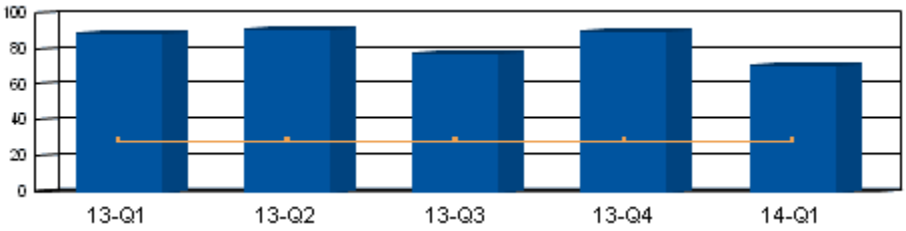
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	88	**28**
13-Q2	91	**28**
13-Q3	77	**28**
13-Q4	90	**28**
14-Q1	70	**28**

Interpretation - Patient And Business:

Some improvement due to the fact that we expanded staffing and were able to improve efficiency. However we have since lost a technologist and have another vacancy. The demand for service overwhelms the single tertiary care magnet. Almost all ambulatory work is routed to KMRI. When possible patients from the west end of the LHIN are referred back to Quinte for MRI imaging.

MRI is critical to many specialties. Particularly the Cancer Care population, neurology, women's health and many of the critical care inpatients. Long wait times negatively impact these patients' journey of care by delaying diagnosis, decison to treat, staging and determining response to treatments to list a few.

Patients become very anxious waiting for a booking. Also many patients are cancelled and rebooked as more urgent cases present themselves. This increases the patient's stress and often results in a complain t to the hospital.

Actions & Monitoring Underway to Improve Performance:

Pursuing approval for a second tertiary care based magnet.
Continue to recruit optimal staffing.
Dedicated booking clerk staffing to ensure bookings are maximized and booking errors are minimized.
Working with application specialists and the radiologists to implement most efficient protocols.

Definition: DATA: Decision Support COMMENTS: Karen Pearson

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, Target 13/14: 28 Days Perf. Corridor: Red >32 Yellow 29-32 Green <=28

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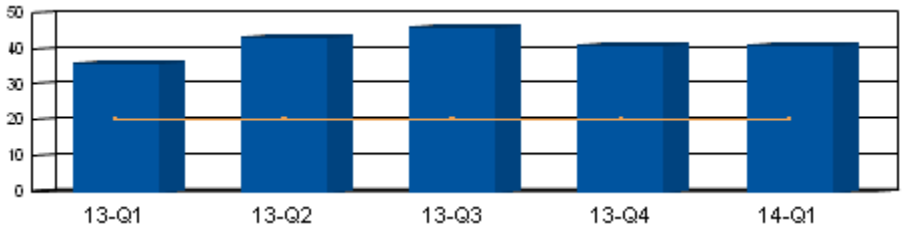
The top sources of GRIDLOCK are addressed.

Indicator: Average # ALC Patients per Day



	Actual	Target
13-Q1	36	**20**
13-Q2	43	**20**
13-Q3	46	**20**
13-Q4	41	**20**
14-Q1	41	**20**

Interpretation - Patient And Business:

The average number of ALC patients remains well above the target for the 5th consecutive quarter. ALC patients awaiting admission to a long term care home account for the majority of the total number. Conversions of patients from acute to ALC-LTC increased in Q1 of 2014. Prior to the implementation of Home First KGH's conversion rate was 0.42 (0.42 patients converting to ALC-LTC per day). In Q1 the conversion rate was 0.45.

Home First admits in Q1 = 47 Patients admitted to Home First would very likely otherwise have been designated ALC-LTC. If not for Home First, the ALC-LTC patient population/conversions would have been much higher.

Reasons for the high numbers of ALC patients include complexity of medical issues preventing admission to Home First, reduction of LTC beds in the community (occurred last year), lost opportunity for access to LTCHs based on priority 1A access for L&A.

Actions & Monitoring Underway to Improve Performance:

Actions in progress include: review of ALC-LTC patients who have remained at KGH for >100 days, review of Home First and LTCH application processes.

Access to convalescent beds (fall 2013) may reduce the number of patients requiring admission to LTCHs.

Definition: DATA: Adrienne Leach COMMENTS: Adrienne Leach

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 Target 13/14: 20
Perf. Corridor: Red >30 Yellow 25-30 Green <25

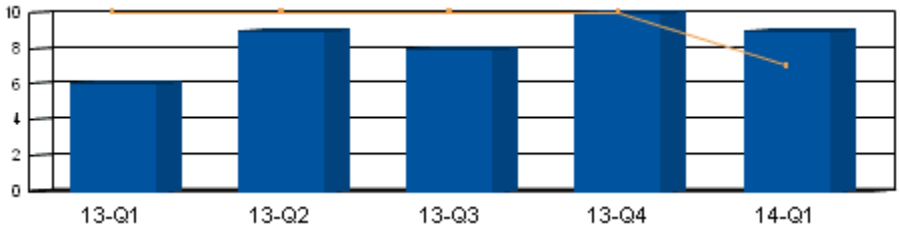
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Percent ALC Days



	Actual	Target
13-Q1	6	**10**
13-Q2	9	**10**
13-Q3	8	**10**
13-Q4	10	**10**
14-Q1	9	**7**

Interpretation - Patient And Business:

Reduction in the percent ALC days reflects a slight increase in patient flow. This flow is attributed to the flow of patients with ALC destinations of rehab primarily.

The number of ALC patients requiring a LTC bed who are waiting >100 days are growing. During the first quarter 2014 there have been between 6-18 ALC-LTC patients who have been at KGH for >100 days. Reasons for this include patient choice (choice of only 1 LTCH), reduced capacity in the community, and crisis placements from the community into LTCHs.

Actions & Monitoring Underway to Improve Performance:

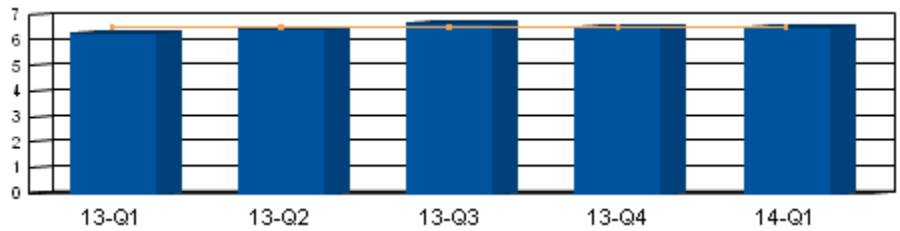
Action is to review process/patients waiting for LTCH >100 days.

Definition: DATA: Decision Support COMMENTS: Adrienne Leach

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%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%

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



	Actual	Target
13-Q1	6.3	**6.5**
13-Q2	6.4	**6.5**
13-Q3	6.7	**6.5**
13-Q4	6.5	**6.5**
14-Q1	6.5	**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 Q1at 6.5 days is right on 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: DATA: Decision Support COMMENTS: John Lott

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 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. Target 13/14: 6.5 Days
Perf. Corridor: Red >6.8 Yellow 6.6-6.8 Red <=6.5

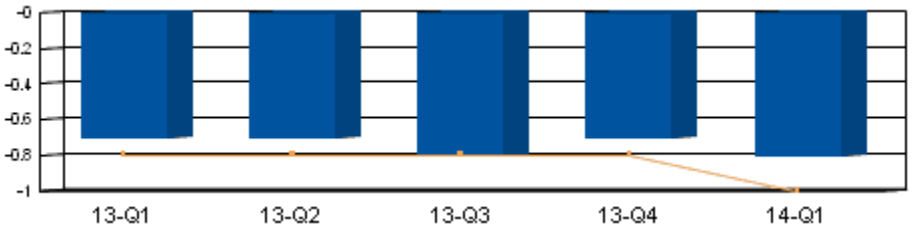
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	-0.7	**-1**
13-Q2	-0.7	**-1**
13-Q3	-0.8	**-1**
13-Q4	-0.7	**-1**
14-Q1	-0.8	**-1**

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q1. The -0.8 day variance for Q1 (fiscal 132/14) indicates that our overall actual length of stay remains below (or better) than our expected length of by 0.8 of a day, trending towards our target of -1.0 days. However, it is important to note that this is calculated on an overall basis. There remains opportunity in 3 of 18 services to achieve expected length of stay. They are the services of Gastroenterology, Obs/Gyn and Neurology.

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: DATA: Decision Support COMMENTS: John Lott

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, Target 13/14: -1.0 Perf. Corridor: Red >= -0.5 Yellow -0.6 to -0.7 Green <= -0.8

Kingston General Hospital

MS #03

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

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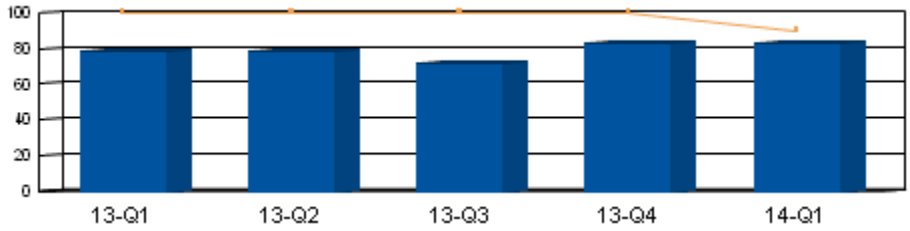
Indicator: Percent of Clinical Services Meeting or Exceeding ELOS Target



	Actual	Target
13-Q1	78	**100**
13-Q2	78	**100**
13-Q3	72	**100**
13-Q4	83	**100**
14-Q1	83	**90**

Interpretation - Patient And Business:

As of Q1 (fiscal 13/14), 83 percent of services (15 of 18) are achieving (or outperforming) their expected length of stay. Despite a status of Yellow, it is of note that this is the best performance of this indicator over the last 3 years. The services that are not currently at their expected length of stay are Gastroenterology, Obs/Gyn, and Neurology. The three services that were over in Q1 totaled a mere 236 patient days collectively. This should be viewed as insignificant.

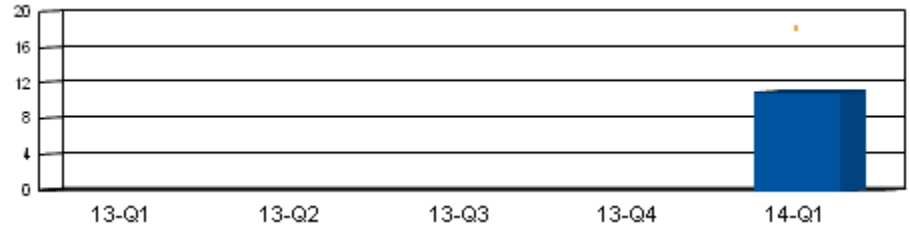
Actions & Monitoring Underway to Improve Performance:

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

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

Target: Target 12/13: 100%, Target 13/14: 90% Perf. Corridor: Red <70% Yellow 70%-89% Green 90%-100%

Indicator: Number of Inpatient by Program Floor Assignment Patient Days Within Budget



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	11	**18**

Interpretation - Patient And Business:

Definition: COMMENTS: Eleanor Rivoire

Inpatient days is a measure of how many days an inpatient spends in a bed in the hospital. This information is stored on the Patient Care System (PCS) of the hospital and is updated on patient admission, discharge, and transfer in real time. Every day at midnight, a report is generated showing where beds are occupied throughout organization. This is referred to as the midnight census. These daily census data are accumulated throughout the year and enable the running of census reports which show aggregate patient days by area (e.g. floors, nursing units, clinical programs). Prior to the beginning of any fiscal year, census data are reviewed for trends and patterns and then used to generate a “patient day budget” by clinical program. The patient day budget aligns with the financial budget for that program and assists with planning staffing levels etc. Actual patient days are then compared to budgeted patients days on a monthly basis.

Target: Target 13/14: 18

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

The top sources of GRIDLOCK are addressed.

Indicator: Reduce the Number of Avoidable Admsisions

	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	1,701	**1292**

Interpretation - Patient And Business:

Within KGH, and as part of the Gridlock Value Stream Mapping initiative, there are and will be improvement cycles that look at ways of creating earlier assessments of patients, greater consistency in decision making criteria and better engagement of community based supports to avoid admissions. One of the 5 priorities underway is specific to consultation in ED which is expected to improve/expedite assessment and decision making about admission.

In Q2, the Patient Flow Task Force will focus on ways to make this avoidable admission data more relevant to individual programs/services and useful for CI work.

KGH is represented and actively participating on LHIN and Health Link teams that are configured and mandated to support improved community/regionally based services (Mental Health redesign; CSR teams) in minimizing individuals having the need to present to the ED (and therefore risk of admission).

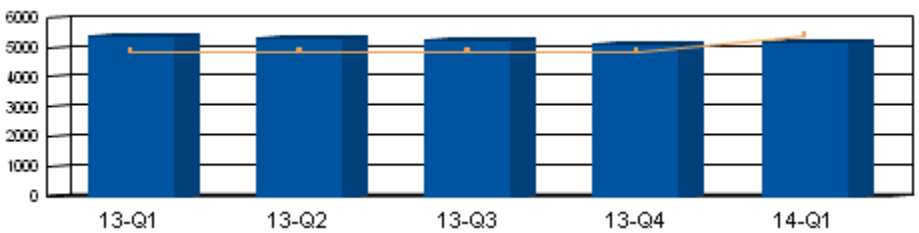
Actions & Monitoring Underway to Improve Performance:

In addition to addressing opportunities for consistency with decision making and patient flow processes within KGH, we will continue work with the Health Links as a provincial and local initiative to support avoidable admissions with targeted supports for individuals who are high users of the acute care system (elderly; chronic conditions; mental health/behavioural support). Similarly, continue work with CCAC, Providence Care and Hotel Dieu Hospital with projects that enable early response in the community to address behavioural support and primary care needs.

Definition: As part of the process of examining the acute care patient journey from the community and entering into the hospital system, it is acknowledged that there are a measureable number of patients with low complexity and low acuity type medical conditions who are being unnecessarily admitted to beds for inpatient hospital treatments. Given the growing pressure on acute care beds and clinical teams, and an acknowledgement that hospitals may not be the best place to treat some of these patients, an effort to analyze and identify avoidable admission is a priority for the organization. Clinicians and managers share the view that beds should only be used to treat acute patients, with more complex conditions. Many clinicians believe that many of these patients could be treated in alternative care settings. However, there are barriers in referring these types of patients. Limited availability of community based acute services and difficulties in organizing the logistics for referring patients to alternative services, involving multiple phone calls resulted in clinicians considering it 'easier to admit, than refer. Analysis will focus on identifying patient volumes with low complexity; low acuity medical conditions had been admitted for inpatient hospital treatments for very short periods of time.

Target: Target 13/14: 5032

Indicator: Total Inpatient Admissions



	Actual	Target
13-Q1	5,383	**4850**
13-Q2	5,284	**4850**
13-Q3	5,256	**4850**
13-Q4	5,130	**4850**
14-Q1	5,193	**5398**

Interpretation - Patient And Business:

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

Definition: DATA: Decision Support COMMENTS: John Lott

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, Target 13/14: 21,589 (5,398/qtr)
Perf. Corridor: Red <15,114 OR > 23,474 Yellow 15,714-17,459 OR 21,341-23,474 Green 17,460-21,340

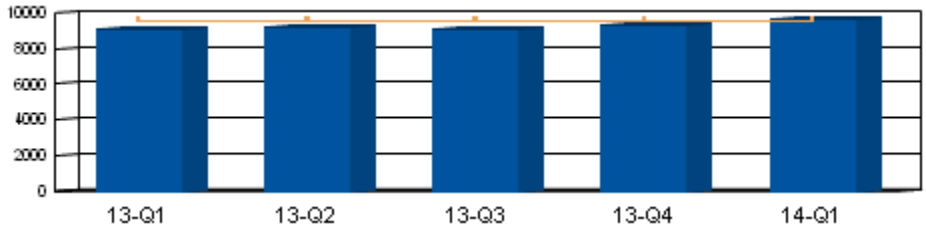
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Total Inpatient Weighted Cases



	Actual	Target
13-Q1	9,060	**9556**
13-Q2	9,172	**9556**
13-Q3	9,080	**9556**
13-Q4	9,272	**9556**
14-Q1	9,609	**9579**

Interpretation - Patient And Business:

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

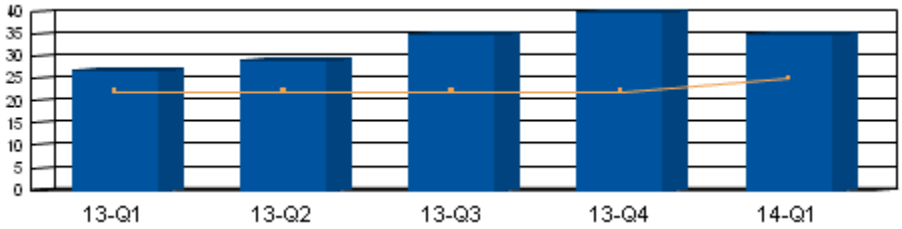
Definition: DATA: Decision Support COMMENTS: John Lott

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: 38224, Target 13/14: 38,316 Perf. Corridor: Red < 30, 579 Or > 45,869 Yellow 30,579-34,401 OR 42,046-45,869 Green 34,402-42,046

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



	Actual	Target
13-Q1	27	**22**
13-Q2	29	**22**
13-Q3	35	**22**
13-Q4	40	**22**
14-Q1	35	**25**

Interpretation - Patient And Business:

The Q4 result of 35 hours is 10 hours longer than the new 25 hour target (22 hours last fiscal). Ninety percent of all patients admitted through the ED wait up to 35 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.
A working group is looking at consultant arrival times and disposition decision times as a priority for improvement identified in the Patient Flow Value Stream Mapping exercise.
Strategy for this year includes identifying top sources of gridlock with recommendations on how to address opportunities identified. Work has started on the first 5 priorities.

Definition: DATA: Decision Support (NACRS) COMMENTS: Julie Caffin

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

Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28

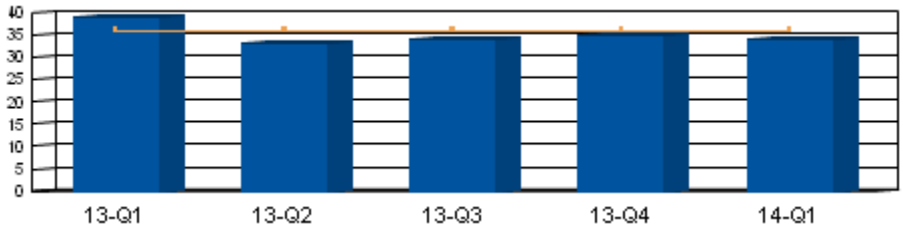
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	39	**36**
13-Q2	33	**36**
13-Q3	34	**36**
13-Q4	35	**36**
14-Q1	34	**36**

Interpretation - Patient And Business:

At the end of Q1, 34 percent of patients admitted from the ED were transferred to an inpatient 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 320 admissions this quarter. Inpatient bed days are also up over last year with days 1437 days in Q1 compared to 843 days at the same time last year. This is 527 days over the target of 910 days.
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. ED physicians are working toward shortening the time to consult. An algorithm to assist with consultation to the appropriate service has been implemented.

Definition: DATA: Decision Support COMMENTS: Julie Caffin

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%, Target 13/14: 36% Perf. Corridor: Red <31% Yellow 31%-35% Green >=36%

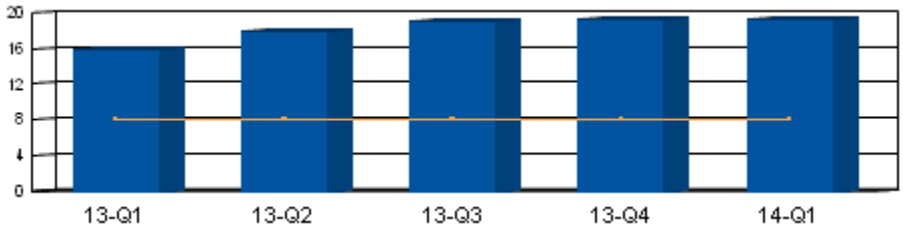
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	16	**8**
13-Q2	18	**8**
13-Q3	19	**8**
13-Q4	19	**8**
14-Q1	19	**8**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for patients admitted with complex conditions is 19.3 hours. Nine of ten patients are moved to an inpatient bed within 19.3 hours of arrival to the department while 10 percent wait longer than 19.3 hours. This has been trending negatively since Q1 of last fiscal. The Q1 result of 19.3 hours is 11.3 hours longer than the 8 hour target. Inpatient days are at 1437 days in Q1 compared to 843 last year Q1. This is 520 days above the planned inpatient days of 910 days.

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 as the result of recommendations that came out of a value stream mapping exercise. The first 5 priorities were identified and teams are working through 90 to 120 day improvement cycles after which a further 5 priorities will be identified.

Definition: DATA: Decision Support COMMENTS: Julie Caffin

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 than 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, Target 13/14: 8 Perf. Corridor: Red >10 Yellow 8-10 Green <8

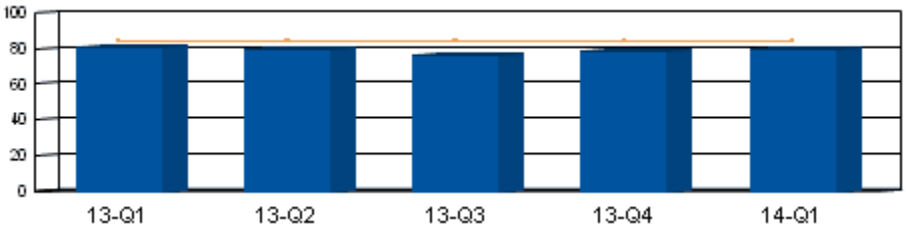
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	81	**84**
13-Q2	79	**84**
13-Q3	76	**84**
13-Q4	78	**84**
14-Q1	79	**84**

Interpretation - Patient And Business:

Based on Q1 results, the Emergency Department is not meeting the target wait time for the percent of patients - CTAS 4 and 5 - discharged within 4 hours. This patient population makes up 25% of all ED visits. Inpatient days in ED were up this quarter at days, an increase of days over same period last year. Admitted patients in ED beds for this length of time combined with a higher proportion of high acuity patients 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 identify and trial 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.
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: DATA: Decision Support COMMENTS: Julie Caffin

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%, Target 13/14: 84% Perf. Corridor: Red <79% Yellow 79%-83% Green >=84%

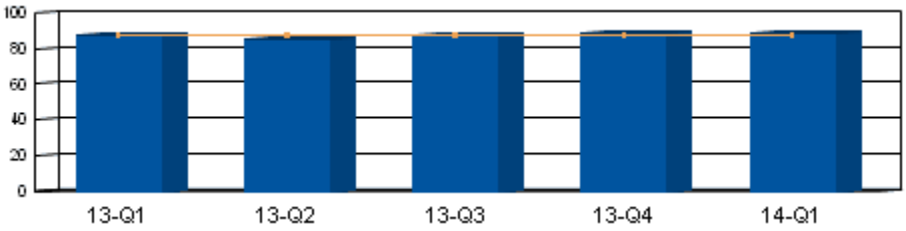
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	87	**87**
13-Q2	85	**87**
13-Q3	87	**87**
13-Q4	89	**87**
14-Q1	88	**87**

Interpretation - Patient And Business:

Based on the Q1 results, the ED has sustained the improvement in the ED wait time meeting or surpassing the 87% target for non-admitted, high acuity patients for 3 consecutive quarters.
This target has been sustained even with a significant increase in visits in this category over the past 2 years.

Actions & Monitoring Underway to Improve Performance:

Work continues to identify and eliminate all delays in the ED visit. Using LEAN principles, we are working to optimize the use of stretchers and chairs to increase capacity resulting in improved time to care. A Project Manager has been hired to assist with continuous improvement initiatives in the ED 90 percent of all patients presenting to the ED are seen by a physician within 2.5 hours. 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) pilots.

Definition: DATA: Decision Support COMMENTS: Julie Caffin

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%, Target 13/14: 87 Perf. Corridor: Red <82% 82%-86% Green >=87%

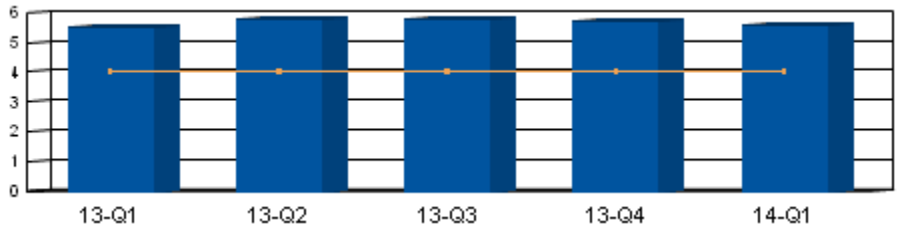
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q1	5.5	**4**
13-Q2	5.8	**4**
13-Q3	5.8	**4**
13-Q4	5.7	**4**
14-Q1	5.6	**4**

Interpretation - Patient And Business:

Based on the Q1 results, KGH ED 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 5.6 hours. The ability to see patients in this category is dependent on available assessment space. With the increase in overall volumes, admitted patients, increased inpatient bed days and a significant increase in higher acuity patients, these patients tend to wait longer for assessment after triage. 90 percent of all patients presenting to the ED are seen by a physician within 2.5 hours of arrival to the department.

Actions & Monitoring Underway to Improve Performance:

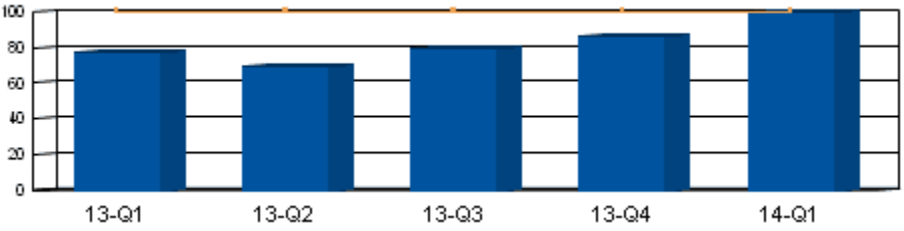
A team of ED staff, physicians and Patient Experience Advisors have been working with LEAN principles to eliminate delays in patient flow through the ED. We have hired a project manager to guide these changes in the ED. The team is also looking at ways to optimize stretcher and chair utilization to increase capacity within the department.

Definition: DATA: Decision Support COMMENTS: Julie Caffin

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, Target 13/14: 4hrs Perf. Corridor: Red >5 Yellow 4-5 Green >=4

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
13-Q1	77	**100**
13-Q2	69	**100**
13-Q3	79	**100**
13-Q4	86	**100**
14-Q1	100	**100**

Interpretation - Patient And Business:

All Wait time contacted volumes were achieved in Q1.

Actions & Monitoring Underway to Improve Performance:

Tremendous success and leadership by the SPA, Cardiac and Diagnostic Imaging programs.

Definition: DATA: Decision Support COMMENTS: Dr. David Zelt

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 F2014: Anorectal, Intestinal IP, Groin Hernia, Ventral Hernia,Paediatric Oral Maxiofascial (Dental) IP and OP, Paediatric Scoliosis,, Paediatric Cleft Lip, MRI, CT,Cancer Surgery, Cardiac (includes Angioplasty, Angiography,Bipass Surgery), Total Joint Revisions.

Target: Target 11/12: 100% Target 12/13: 100%, Target 13/14: 100% Perf. Corridor: Red <75% Yellow 75%-90% Green >=90%

Patient- and family-centred care standards are consistently demonstrated throughout KGH

Green

Strategic Direction	KGH 2015 outcome	Indicator
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	Percent adoption of patient and family centred standards
	KGH is recognized as a centre of excellence in interprofessional education	

Improvement Priorities
Increase adoption of patient- and family-centred care standards in every clinical area

1. **What is our actual performance on the indicator for this milestone as listed above?**
A workplan has been developed that includes activities for each quarter. In Q1, a project team was created to oversee this priority improvement. There are 5 Patient and Family Centred (PFCC) standards that will be the focus of work over the year. Communication of the objective and chosen standards has begun.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
The PFCC standards that have been selected include: identification badges; Customer Service training (AIDET), white boards in the patient room; patient led feedback forums; and hourly patient rounds. Depending on the area of the hospital, a specific number or all of the standards will be supported with education, implemented and monitored using objective auditing processes. Individual teams have been set up for each of the 5 standards, and each includes a patient experience advisor.

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

4. **What new tactics are planned to ensure this milestone is met?**
We will need to further communicate expectations to all staff and physicians and offer support where needed. Further education will be rolled out. Once an auditing tool is created audits will begin with a tentative date of November 30th.

Kingston General Hospital

MS #04

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
Bring to life new models of interprofessional care and education	Patient and family-centered care standards are consistently demonstrated throughout KGH	Percent Adoption of Patient and Family Centered Care Standards - (QIP)	N/A	N/A	N/A	N/A	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

MS #04

Bring to life new models of interprofessional care and education

Patient and family-centered care standards are consistently demonstrated throughout KGH

Indicator: Percent Adoption of Patient and Family Centered Care Standards - (QIP)

	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1		100

Interpretation - Patient And Business:

A project team has been created which will oversee the entire initiative. Individual teams have been set up for each of the 5 standards. Communication of the standards has begun. Work is underway for the development of an auditing tool.

Actions & Monitoring Underway to Improve Performance:

We will need to further communicate expectations to all staff and physicians and offer support where needed. Further education will be rolled out. Once an auditing tool is created audits will begin with a tentative date of November 30th.

Definition: COMMENTS: Darryl Bell

With the implementation of the Interprofessional Collaborative Practice Model (ICPM), specific practices have been introduced to support patient- and family-centred care. As well, with the evolution of patient engagement, there have been new and leading practices introduced to enable continuous improvement and transformation of the patient experience. To support the KGH Strategy of Achieving Outstanding Care, Always, it is critical for these practices or corporate standards to be consistently applied across the organization.
With the input of Patient Experience Advisors, five standards have been identified as ones where KGH will focus support with education and monitoring to support adoption and consistent demonstration. These include:
- Completion of white boards
- Use of Identification badges consistent with KGH policy
- A.I.D.E.T. (acknowledge, introduce, duration, explanation and thanks)
- Hourly rounding
- Patient feedback forums.

Processes will be developed to support the education and implementation of the practices, which will then be audited with report to each clinical and service area (Note: not all standards will be applicable to all areas of the hospital). The goal is for an overall 80% corporate compliance rate for each standard practice.

Target: Target 13/14: 100% Perf. Corridor: Red <50% Yellow 50%-79% Green >=80%

Externally funded research at KGH has increased to 45% Green

Strategic Direction	KGH 2015 outcome	Indicator
Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	4% Increase of externally funded Research dollars at KGH

Improvement Priorities
Advance the plan for a Kingston-wide health research enterprise
Increase the profile of KGH research

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

   Milestone on track for being green. Actual % value will be reported in Q2/Q3 once all financial reports received from external sources.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** (Name the tactic and describe the status)

   Increase the profile of KGH research:

   Knowledge transformation plan created with external service provider.

   Advance the plan for a Kingston-wide health research enterprise:

   Partnership plans for joint venture enterprise underway. Monthly meetings with CEOs, Dean FHS, and Director of the Monieson Centre, Queen's School of Business continue with coming to terms with creating an agreement on the contributions of the partners. Assets of partners defined.

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

   Yes.

4. **What new tactics are planned to ensure this milestone is met?**

   Increase the profile of KGH research:

   - Black Tie Video launched for Clinical Investigation Unit fundraising.
   - Research Strategic Plan launched.
   - Video researcher profiles of new clinician scientists launched.
   - F2013 Research Report (annual event).
   - KGHRI branding and website development.
   - Communication/marketing plan developed for KGHRI.
   - Research showcase, cafes and other forums organized (annual event).

   Advance the plan for a Kingston-wide health research enterprise:

   - Needs assessment completed.
   - Future commitments defined.
   - Management and governance structure determined.
   - Joint venture contract signed.

Kingston General Hospital

MS #05

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Cultivate patient oriented research	Externally funded research at KGH has increased to 45%	4% Increase of Externally Funded Research Dollars at KGH	N/A	G	G	G	G	↑
		Active Clinical Trials	G	G	G	G	G	↑
		Clinical Trials Generating Revenue	G	G	G	G	G	↑
		New Clinical Trials	R	R	Y	Y	R	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

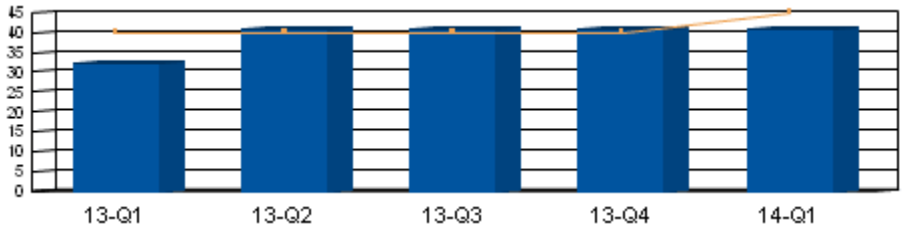
Kingston General Hospital

MS #05

Cultivate patient oriented research

Externally funded research at KGH has increased to 45%

Indicator: 4% Increase of Externally Funded Research Dollars at KGH



	Actual	Target
13-Q1	32	**40**
13-Q2	41	**40**
13-Q3	41	**40**
13-Q4	41	**40**
14-Q1	41	**45**

Interpretation - Patient And Business:

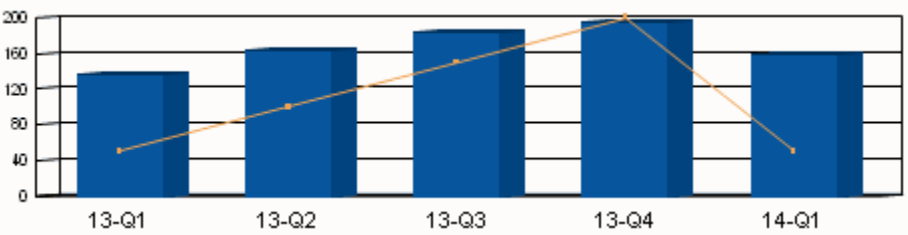
KGH Research Annual Report will be released in fall 2013 and the data for percent increase in research funds will be recorded in Q2/Q3. Real F2013 data will be used for reporting of F2014 data for this performance indicator since real figures for F2014 will not be available until September 2014. 95% of the data is obtained from external sources and is not available on a quarterly basis for reporting.

Definition: DATA: Veronica Harris McAllister COMMENTS: Veronica Harris-McAllister

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% Target 2013/14: 45% Perf. Corridor: Red <42% Yellow 42%-44% Green >=45

Indicator: Active Clinical Trials



	Actual	Target
13-Q1	136	**50**
13-Q2	163	**100**
13-Q3	184	**150**
13-Q4	195	**200**
14-Q1	158	**50**

Interpretation - Patient And Business:

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

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

Definition: DATA: V. Harris-McAllister COMMENTS: V. Harris-McAllister

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. Target 13/14: 200 Perf. Corridor: Red <160 Yellow 160-179 Green >=180

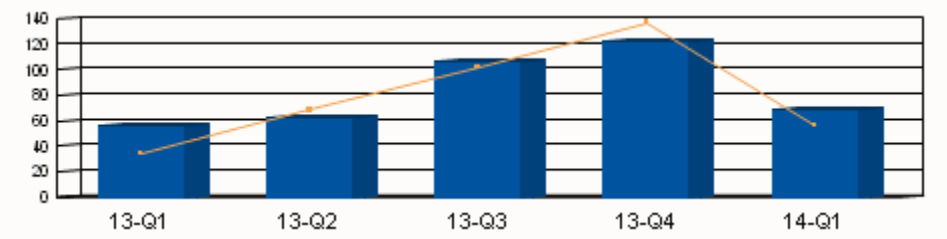
Kingston General Hospital

MS #05

Cultivate patient oriented research

Externally funded research at KGH has increased to 45%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
13-Q1	56	**34**
13-Q2	63	**68**
13-Q3	107	**102**
13-Q4	123	**137**
14-Q1	69	**56**

Interpretation - Patient And Business:

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

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

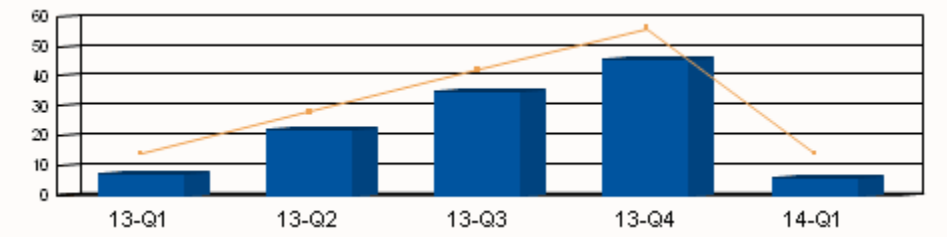
Definition: DATA: Veronica Harris-McAllister COMMENTS: Veronica Harris-McAllister

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, Target 13/14: 137 Perf. Corridor: Red <110 Yellow 110-122 Green >=123

Indicator: New Clinical Trials



	Actual	Target
13-Q1	7	**14**
13-Q2	22	**28**
13-Q3	35	**42**
13-Q4	46	**56**
14-Q1	6	**14**

Interpretation - Patient And Business:

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

Business Perspective: Based on the fiscal year to date, KGH is behind target by the end of the first quarter (Q1). 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. In general, the summer is typically slow for the initiation of new clinical trials.

Definition: DATA: Veronica Harris-McAllister COMMENTS: Veronica Harris-McAllister

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, Target 13/14: 56 Trials Perf. Corridor: Red <45 Yellow 45-49 Green >=50

Protocols for targeted patient populations are in place and reflect KGH's regional role

Yellow

Strategic Direction	KGH 2015 outcome	Indicator
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	A protocol to manage each improvement priority in adopted
	Best evidence used to guide practice	

Improvement Priorities
Reduce the number of patients waiting for transfer to other facilities
Reduce 30-day readmission rates
Quality Based Procedures are effectively delivered

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

This milestone is comprised of 23 metrics focused on volumes. Thirteen are green and 3 are yellow (73% favourable). Of the 6 red indicators 3 are QBP with volumes related to urgent, non scheduled activity. Patients waiting for transfer to other facilities longer than 48 hours is also red. The two indicators looking at 30 day readmission rates are both red.

2. What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone? (Name the tactic and describe the status)

Reduce the number of patients waiting for transfer to other facilities: Policy and Procedure documentation has been developed and presented to the SE LHIN partners at SECHEF. All members unanimously accepted the policy. Procedure development is in progress.
Reduce 30-day readmission rates: This indicator will be incorporated into the work plan for JQUIC in September.
Quality Based Procedures are effectively delivered: All QBP teams have begun analysis of the provincial toolkit and analysis of volumes (Joints, Stroke, CHF, COPD, Vascular and Endoscopy).

3. Are we on track to meet the milestone by year end?
The improvement priorities will be on target. The Milestone is at risk with over activity in a number of areas.

4. What new tactics are planned to ensure this milestone is met? N/A

Kingston General Hospital

MS #06

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Increase our focus on complex-acute and specialty care	Regional Protocols for targeted patient populations are in place and reflect KGH's role	A Protocol to Manage Each Improvement Priority is Adopted	N/A	N/A	N/A	N/A	Y	
		The Number of Patients Waiting for Transfer to Other Facilities is Reduced by 50%	N/A	N/A	N/A	N/A	R	
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility	R	N/A	N/A	N/A	N/A	
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile - (QIP)	R	Y	G	G	R	↓
		QBP (Quality Based Procedure) - COPD	N/A	N/A	N/A	N/A	Y	
		QBP (Quality Based Procedure) - Heart Failure (CHF)	N/A	N/A	N/A	N/A	R	
		QBP (Quality Based Procedure) - Primary Hip & Knee Replacement Volume	Y	G	G	G	Y	↓
		QBP (Quality Based Procedure) - Stroke	N/A	N/A	N/A	N/A	R	
		QBP (Quality Based Procedure) - Vascular	N/A	N/A	N/A	N/A	R	
		Ambulatory Care Volumes	G	G	G	G	G	↑
		Cardiac - Angiography Volumes	G	G	G	G	G	↑
		Cardiac - Angioplasty Volumes	G	G	G	Y	Y	↓
		Cardiac - Bypass Volumes	G	G	Y	G	G	↑
		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		MRI Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑

61	13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Emergency Department Admitted Patient Volumes – All Levels of Acuity	G	G	G	G	G	
Emergency Department Non-Admitted Low Acuity (CTAS 4&5) volumes	G	G	G	G	G	
Emergency Department Non-Admitted Patient Visits – High Acuity	G	G	G	G	G	
Kidney Transplants	G	G	G	Y	Y	
OR Cases (Inpatient and Outpatient)	G	G	G	G	G	
OR Hours (Inpatient & Outpatient)	G	G	G	G	G	
Stem Cell Transplants	G	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	
Percent of Contracted Volumes Achieved	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 

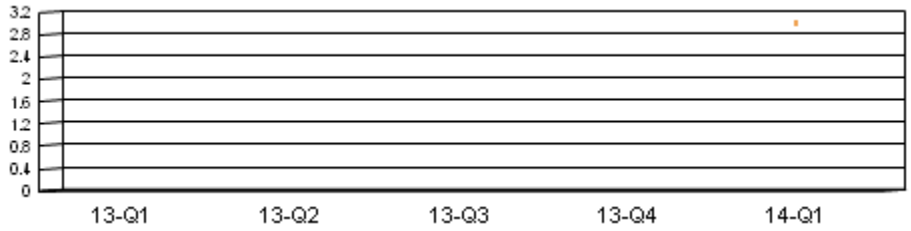
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: A Protocol to Manage Each Improvement Priority is Adopted



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1		3

Interpretation - Patient And Business:

The indicator is comprised of 3 improvement priorities:
1. Reduce the number of patients waiting to transfer to other facilities
2. Reduce the 30 day readmission rates
3. Optimize practices to manage and deliver Quality Based Procedures

Policy and Procedure has been created and accepted the SE LHIN partners. Implementation is underway.
Data reporting cards are in development for 30 day readmission rate for the SELHIN defined disease groups.
Six new Quality Based Procedure teams have been created and are in process of utilizing the MoHLTC toolkits to set out initiatives to meet volumes and quality metrics.

Actions & Monitoring Underway to Improve Performance:

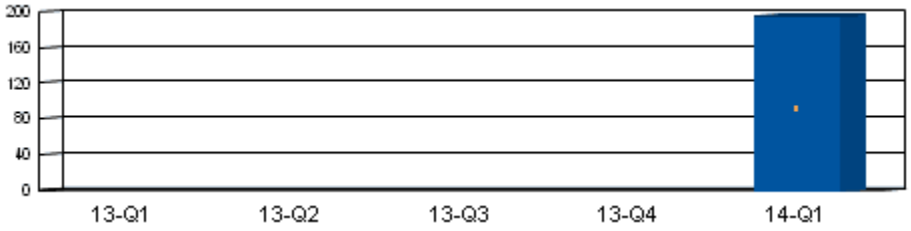
Working with the SECHEF LHIN group will focus on implementation of the policy and procedure document for transferring patients. Once 30 day readmission report cards are created, data will be analyzed at JQUIC and clinical departments to develop initiatives to reduce unnecessary readmissions. Based upon experience from the first year of the Orthopedic QBP, critical to the success of all the Quality Based Procedure teams will be the linkage to Medical Records and the data capture process.

Definition: DATA: Jennifer Foster COMMENTS: Dr.David Zelt

Health System Funding Reform (HSFR) by the Ministry of Health is a multi-year program changing the funding model to hospitals. The Quality Based Program (QBP) will become 30% of funding for clinical care linking clinical services volume targets and wait times) to quality of care outcomes. Fiscal 2012/13 enrolled hip and knee replacements, renal disease and cataracts into QBP. This current fiscal year 2013/14 has 6 additional disease groups added to QBP: Chronic obstructive pulmonary disease, congestive heart failure, stroke, colonoscopy, vascular surgery and systemic (chemo) therapy.

Target: Target 13/14: 3 Perf. Corridor: Red 0 Yellow 1 Green >=2

Indicator: The Number of Patients Waiting for Transfer to Other Facilities is Reduced by 50%



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	194	90

Interpretation - Patient And Business:

A new indicator. Score card and data collection is in development with Decision Support. Review of this indicator will be through Patient Flow Task Force.

Definition: DATA: Decision Support COMMENTS: Dr.David Zelt

There are inpatients in the KGH that require transfer to another facility after their acute episode (at KGH) is completed. Patients waiting for transfer are closely tracked by the organization via the admitting department. The time it takes for transfer is readily calculated from the data collected. The amount of time a patient waits is an important performance measure as these patients are occupying acute care beds while they wait. With access to acute care beds being so critical, it is essential that this wait time is minimized to the greatest degree.

Target: Target 13/14: 360 (90/qtr) Perf. Corridor: Red >118 cases/qtr Yellow 101-117 cases/qtr Green <100 cases/qtr

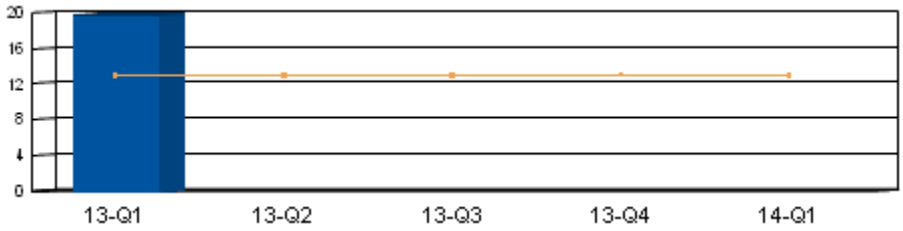
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

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



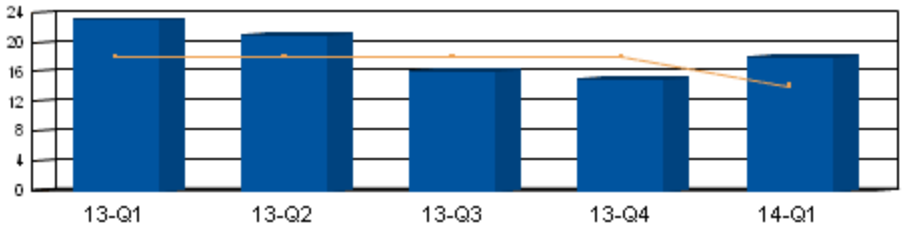
	Actual	Target
13-Q1	19.8	**12.9**
13-Q2		**12.9**
13-Q3		**12.9**
13-Q4		**13.0**
14-Q1		**12.9**

Interpretation - Patient And Business:

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%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%

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



	Actual	Target
13-Q1	23	**18**
13-Q2	21	**18**
13-Q3	16	**18**
13-Q4	15	**18**
14-Q1	18	**14**

Interpretation - Patient And Business:

Data reporting cards are in development for 30 day readmission rate for the SELHIN defined disease groups.

Actions & Monitoring Underway to Improve Performance:

Once 30 day readmission report cards are created, data will be analyzed at JQUIC and clinical departments to develop initiatives to reduce unnecessary readmissions

Definition: DATA: Decision Support COMMENTS: Dr.David Zelt

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%, Target 13/14: 14% Perf. Corridor: Red >17% Yellow 14%-17% Green <=14%

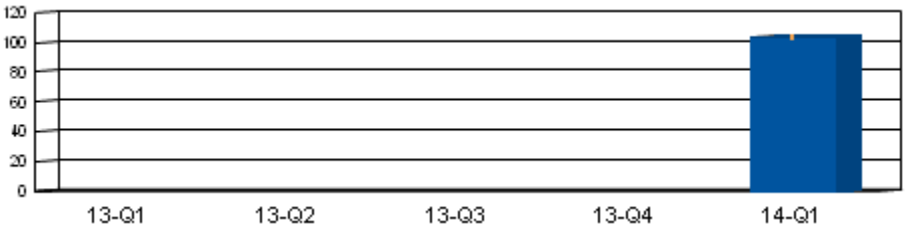
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: QBP (Quality Based Procedure) - COPD



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	104	**103**

Interpretation - Patient And Business:

At the end of Q1 admissions of patients who have a COPD (typically an exacerbation of this condition) is as expected. The results show projected volume-based implementation of the QBP for COPD, the qualifying cases (target) compared with actual volumes. The patients included here are 'unscheduled' and are typically admitted through the ED-flow, the volume variation seen is challenging to 'control'.

Actions & Monitoring Underway to Improve Performance:

At this stage of the QBP implementation it is challenging to confirm impact to the organization and clinical program/service. The volume calculation has been estimated and at this time (Q1) there are no 'prices' set for the clinical activity in question. A lead group has been established and in Q2 will undertake an assessment of the current state service provision relating to the service quality aspects identified to in the QBP guidance document.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt

A core component of the Ministry of Health's health system funding reform a new dimension in procedure based funding has been introduced for fiscal 11/12. It is called Quality Based Procedure (QBP) funding. The QBPs target a set a clinical areas that demonstrate significant opportunity to introduce evidence into clinical pathways; reduce practice variation, attain cost efficiencies; and catalyze alignment of quality with funding. At the core of QBP is "price" and "volume" calculation designed to create incentives for providers to adopt best-practice in their care delivery models. QBPs has a 3 year implementation horizon (2014) which when fully implemented will account for approximately 30 percent of hospital budgets.
In year two of the implementation (commencing April 2013), a QBP for Chronic Obstructive Pulmonary Disease (COPD) has been introduced. Chronic obstructive pulmonary disease is a disease state that is characterized by a limitation in airflow that is not fully reversible. This airflow limitation is usually progressive and associated with an abnormal inflammatory response of the lungs to noxious particles or gases. COPD was chosen as a QBP using an evidence- and quality-based selection framework that identifies opportunities for process improvements, clinical redesign, improved patient outcomes, enhanced patient experience, and potential cost savings.

Target: Target 13/14: 411

Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: QBP (Quality Based Procedure) - Heart Failure (CHF)

	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	87	**75**

Interpretation - Patient And Business:

At the end of Q1 more patients with a diagnosis of Heart Failure have been admitted than expected. The results show projected volume-based implementation of the QBP for CHF, the qualifying cases (target) compared with actual volumes. The patients included here are 'unscheduled' and are typically admitted through the ED-flow, the volume variation seen is challenging to 'control'.

Actions & Monitoring Underway to Improve Performance:

At this stage of the QBP implementation it is challenging to confirm impact to the organization and clinical program/service. The volume calculation has been estimated and at this time (Q1) there are no 'prices' set for the clinical activity in question. A lead group has been established and in Q2 will undertake an assessment of the current state service provision relating to the service quality aspects identified to in the QBP guidance document.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt

A core component of the Ministry of Health's health system funding reform a new dimension in procedure based funding has been introduced for fiscal 11/12. It is called Quality Based Procedure (QBP) funding. The QBPs target a set a clinical areas that demonstrate significant opportunity to introduce evidence into clinical pathways; reduce practice variation, attain cost efficiencies; and catalyze alignment of quality with funding. At the core of QBP is "price" and "volume" calculation designed to create incentives for providers to adopt best-practice in their care delivery models. QBPs has a 3 year implementation horizon (2014) which when fully implemented will account for approximately 30percent of hospital budgets.
In year two of the implementation (commencing April 2013), a QBP for Congestive Heart Failure (CHF) has been introduced. CHF is a complex clinical syndrome of symptoms and signs suggesting that the heart muscle is weakened and the heart as a pump is impaired; it is caused by structural or functional abnormalities and is the leading cause of hospitalization in elderly Ontarians. CHF was chosen as a QBP using an evidence- and quality-based selection framework that identifies opportunities for process improvements, clinical redesign, improved patient outcomes, enhanced patient experience, and potential cost savings.

Target: Target 13/14:301

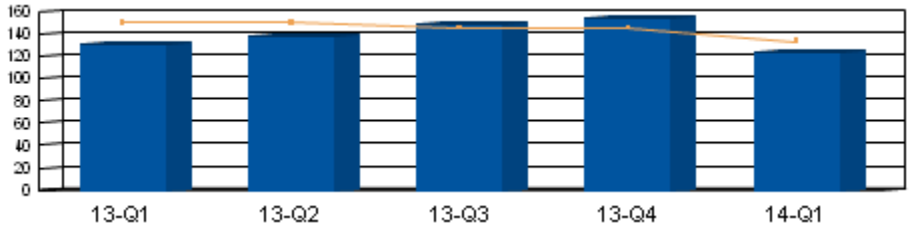
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

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



	Actual	Target
13-Q1	131	**150**
13-Q2	138	**150**
13-Q3	148	**145**
13-Q4	154	**145**
14-Q1	124	**133**

Interpretation - Patient And Business:

For 2013-2014 new QBP volumes were received: primary hips- 194 and primary knees 338. This is an overall decrease of 49 funded volumes from the previous year.

For Q1 there were 18 cancelled surgery cases due to Gridlock (6), no available bed (8) along with 4 cases for other reasons (emergency case cancellation, patient no show, improper booking, and broken equipment.

Actions & Monitoring Underway to Improve Performance:

QBP volumes are monitored monthly by SPA leadership and the Wait Time Committee.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

A core component of the Ministry of Health's health system funding reform a new dimension in procedure based funding has been introduced for fiscal 11/12. It is called Quality Based Procedure (QBP) funding. The QBPs target a set a clinical areas that demonstrate significant opportunity to introduce evidence into clinical pathways; reduce practice variation, attain cost efficiencies; and catalyze alignment of quality with funding. At the core of QBP is "price" and "volume" calculation designed to create incentives for providers to adopt best-practice in their care delivery models. QBPs has a 3 year implementation horizon.(2014) which when fully implemented will account for 30 percent of hospital budgets. In year one of the implementation (commencing April 2012), primary unilateral hip replacement, primary unilateral knee replacement, cataracts, and chronic kidney disease represent the first round of the QBP initiative.

Target: Target 13/14: 532 Perf. Corridor: Red <=521 or >581 Yellow 522-580 Green 581

Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: QBP (Quality Based Procedure) - Stroke

	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	88	**67**

Interpretation - Patient And Business:

At the end of Q1 more patients having had a stroke have been admitted than projected. The results show projected volume-based implementation of the QBP for Stroke, the qualifying cases (target) compared with actual volumes. The patients included here are 'unscheduled' and are typically admitted through the ED-flow, the volume variation seen is challenging to 'control'.

Actions & Monitoring Underway to Improve Performance:

At this stage of the QBP implementation it is challenging to confirm impact to the organization and clinical program/service. The volume calculation has been estimated and at this time (Q1) there are no 'prices' set for the clinical activity in question. A lead group has been established and in Q2 will undertake an assessment of the current state service provision relating to the service quality aspects identified to in the QBP guidance document.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt

A core component of the Ministry of Health's health system funding reform a new dimension in procedure based funding has been introduced for fiscal 11/12. It is called Quality Based Procedure (QBP) funding. The QBPs target a set a clinical areas that demonstrate significant opportunity to introduce evidence into clinical pathways; reduce practice variation, attain cost efficiencies; and catalyze alignment of quality with funding. At the core of QBP is "price" and "volume" calculation designed to create incentives for providers to adopt best-practice in their care delivery models. QBPs has a 3 year implementation horizon (2014) which when fully implemented will account for approximately 30 percent of hospital budgets.
In year two of the implementation (commencing April 2013), a QBP for Stroke has been introduced. A stroke is a sudden loss of brain function caused by the interruption of flow of blood to the brain (ischemic stroke) or the rupture of blood vessels in the brain (hemorrhagic stroke). The interruption of blood flow or the rupture of blood vessels causes brain cells (neurons) in the affected area to die. The longer the brain goes without oxygen and nutrients supplied by the blood, the greater the risk of permanent brain damage.
Strokes can also result in uncontrolled bleeding, causing permanent brain damage. Stroke is the leading cause of adult disability in Canada and the third leading cause of death. Stroke was chosen as a QBP using an evidence- and quality-based selection framework that identifies opportunities for process improvements, clinical redesign, improved patient outcomes, enhanced patient experience, and potential cost savings.

Target: Target 13/14: 268

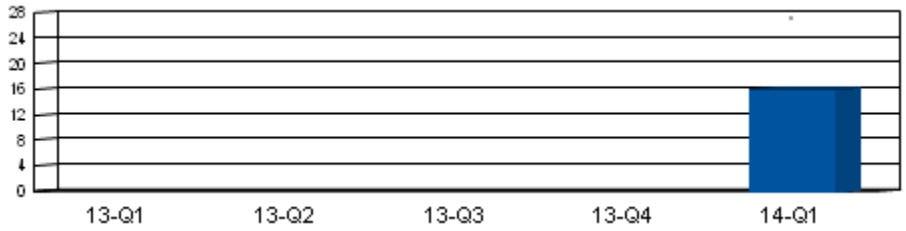
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: QBP (Quality Based Procedure) - Vascular



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	16	**27**

Interpretation - Patient And Business:

For Q1 due to the lack of QBP elective patient case volumes on the waiting list the service was not able to meet the established target for these specialized procedures. Urgent/emergency cases are not counted in this QBP.

Actions & Monitoring Underway to Improve Performance:

QBP working group established with the vascular service to monitor volumes along with the Wait Time Committee and SPA program council.

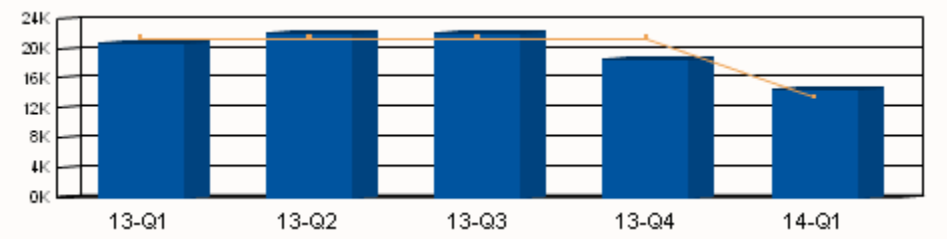
Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

A core component of the Ministry of Health's health system funding reform a new dimension in procedure based funding has been introduced for fiscal 11/12. It is called Quality Based Procedure (QBP) funding. The QBPs target a set a clinical areas that demonstrate significant opportunity to introduce evidence into clinical pathways; reduce practice variation, attain cost efficiencies; and catalyze alignment of quality with funding. At the core of QBP is "price" and "volume" calculation designed to create incentives for providers to adopt best-practice in their care delivery models. QBPs has a 3 year implementation horizon (2014) which when fully implemented will account for approximately 30 percent of hospital budgets.

In year two of the implementation (commencing April 2013), a QBP for elective aortic aneurysm surgery has been introduced. An aortic aneurysm is a localized bulge or weakness of the aorta which can result in rupture and death. Any artery can be involved but aneurysms most commonly involve the infra renal aorta. The major complication is aneurysm rupture, which requires emergency surgery to prevent death. Elective aortic aneurysm surgery was chosen as a QBP using an evidence- and quality-based selection framework that identifies opportunities for process improvements, clinical redesign, improved patient outcomes, enhanced patient experience, and potential cost savings.

Target: Target 13/14: 107

Indicator: Ambulatory Care Volumes



	Actual	Target
13-Q1	20,796	**21323**
13-Q2	22,085	**21323**
13-Q3	22,068	**21323**
13-Q4	18,613	**21323**
14-Q1	14,551	**13386**

Interpretation - Patient And Business:

New target volumes in place reflect in the shift of patient ambulatory activity to HDH.

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to monitor case volumes on a monthly basis.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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 Target 13/14: 53545

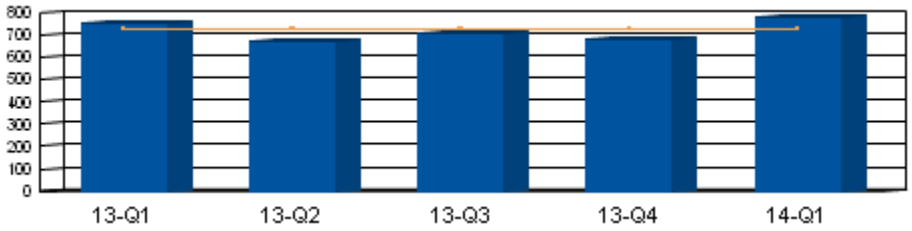
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: Cardiac - Angiography Volumes



	Actual	Target
13-Q1	755	**725**
13-Q2	674	**725**
13-Q3	711	**725**
13-Q4	678	**725**
14-Q1	776	**725**

Interpretation - Patient And Business:

Cardiac Angiography volumes are above n the target volumes in Q1. Procedures are being done well within the recommended wait times for all angiography. There was a large increase in volumes during the month of June due in part to a change in referral pattern from Brockville and Perth Smith Falls. These volumes are in line with Q1 volumes last fiscal but the highest since Q2 2012.

Actions & Monitoring Underway to Improve Performance:

Funded volumes for this fiscal are not known at the time of Q1 reporting.

Definition: DATA: Katelyn Balchin COMMENTS: Julie Caffin

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.
These numbers are Ontario Funded Volumes only.

Target: Baseline 08/09: 1709, Target 09/10: 3100, Target 10/11: 3100, Target 11/12: 2900, Target 12/13: 2900 Target 13/14: 2,900

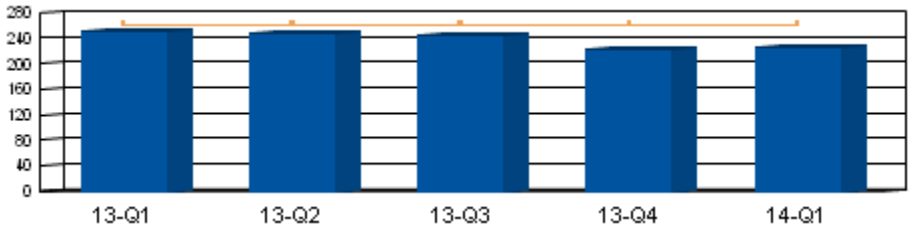
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: Cardiac - Angioplasty Volumes



	Actual	Target
13-Q1	252	**262**
13-Q2	248	**262**
13-Q3	244	**262**
13-Q4	222	**262**
14-Q1	227	**262**

Interpretation - Patient And Business:

Cardiac Angioplasty volumes are slightly below target in Q1. No concerns as funded base volumes are more than 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 resulting in 0 days wait time. 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 of this procedure when appropriate.

Actions & Monitoring Underway to Improve Performance:

Demand has remained steady and is consistent with last year's volumes. This trend in volumes is consistent across the province. Approximately 30% of angiographies lead to angioplasty which is in line with the provincial average. Funded volumes for this fiscal are not known at the time of Q1 reporting.

Definition: DATA: Katelyn Balchin COMMENTS: Julie Caffin

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.
These numbers are Ontario Funded Volumes only.

Target: Baseline 08/09: 1084, Target 09/10: 1150, Target 10/11: 1150, Target 11/12: 1050, Target 12/13: 1050, Target 13/14: 2,900

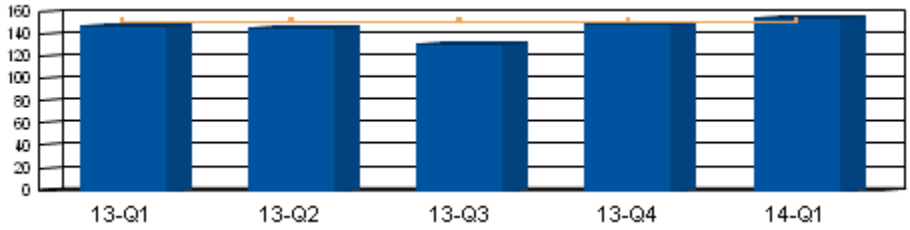
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: Cardiac - Bypass Volumes



	Actual	Target
13-Q1	147	**151**
13-Q2	145	**151**
13-Q3	131	**151**
13-Q4	148	**151**
14-Q1	155	**151**

Interpretation - Patient And Business:

Cardiac surgery volumes are trending above target volumes at the end of Q1. Maximum recommended wait times for elective bypass surgeries are being met 100% of the time.
At the end of Q1, there was a significant waitlist starting to accumulate as a result of increased referrals. This is a concern going into Q2 as there is a loss of operating room time during July and August.

Actions & Monitoring Underway to Improve Performance:

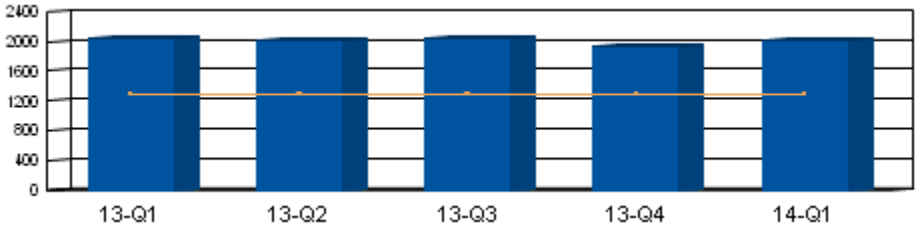
Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Programs and the Wait Times Committee in order to achieve target volumes and wait times and to mitigate cancellations. Surgical volumes and wait times are monitored by the Cardiac Care Network (CCN) of Ontario. The monthly reports generated by the CCN allow us to benchmark against peer hospitals and monitor trends across the province. Funded volume targets for the new fiscal year have not yet been determined by the MoH.
Recruitment for a 4th cardiac surgeon is complete with an anticipated start date of July 2013.

Definition: DATA: Katelyn Balchin COMMENTS: Julie Caffin

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.
These numbers are Ontario Funded Volumes only.

Target: Target 10/11: 580, Target 11/12: 606, Target 12/13: 582, Target 13/14: 2,900

Indicator: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
13-Q1	2,032	**1286**
13-Q2	2,026	**1286**
13-Q3	2,033	**1286**
13-Q4	1,945	**1286**
14-Q1	2,005	**1287**

Interpretation - Patient And Business:

KGH continues to exceed the target as 2 CTs are in operation and base funding and hours are only applied to one CT. The operation of the 2 CTs is necessary to support many critical services at KGH.

Actions & Monitoring Underway to Improve Performance:

Continue with present operations.

Definition: DATA: Decision Support COMMENTS: Karen Pearson

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, Target 13/14: 5,146 hrs
Perf. Corridor: Red <3,788 or >6,313 Yellow 3,788 - 4,544 or 5,556 - 6,313 Green 4,545 - 5,555

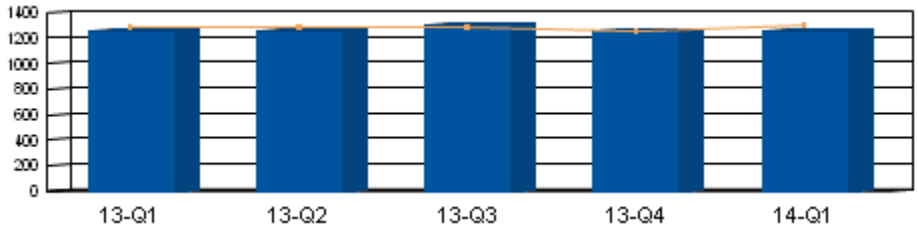
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
13-Q1	1,262	**1283**
13-Q2	1,250	**1283**
13-Q3	1,298	**1283**
13-Q4	1,257	**1250**
14-Q1	1,254	**1300**

Interpretation - Patient And Business:

Meeting target due to expanded staffing levels.

Optimum staffing allows for expanded hours which results in more exams being completed. In order to further improve patient throughput we must staff so that there is at least 2 MRI technologists on every shift. This ensures a safe environment for the technologists and the patient. It also allows for a much greater throughput of patients.

Actions & Monitoring Underway to Improve Performance:

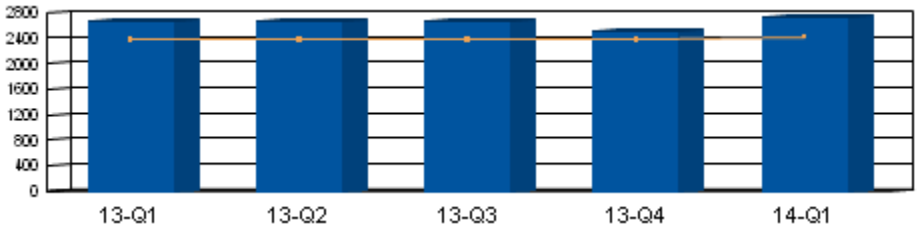
Target hours are being met. Now we must focus on improving patient throughput during these hours. This will decrease wait times and provide the ordering physicians the required MRI results in a timeframe that supports their patients' diagnosis and treatment.

Definition: DATA: Decision Support COMMENTS: Karen Pearson

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. As of Q4 12/13 Target changed to 5000 hrs., Target 13/14: 5,200 Perf. Corridor: Red < 4,160 or > 6,241 Yellow 4,160 - 4,679 or 5,721 - 6,241 Green 4,680 - 5720

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



	Actual	Target
13-Q1	2,658	**2370**
13-Q2	2,683	**2370**
13-Q3	2,657	**2370**
13-Q4	2,520	**2370**
14-Q1	2,736	**2416**

Interpretation - Patient And Business:

Emergency Department admitted patient volumes are above target by 322 admissions at the end of Q1. Admitted patient volumes for the ED in Q1 are 80 admissions more than same period last year.
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: DATA: Decision Support COMMENTS: Julie Caffin

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, Target 13/14: 9,663

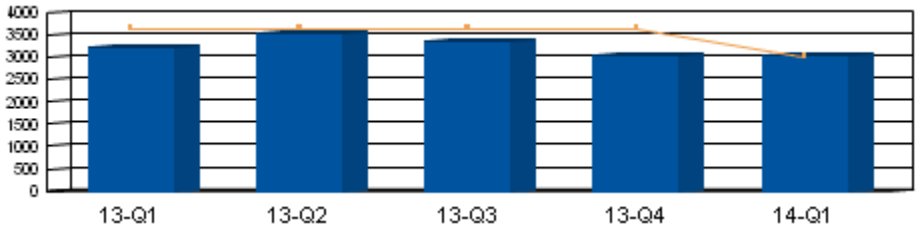
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

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



	Actual	Target
13-Q1	3,242	**3647**
13-Q2	3,547	**3647**
13-Q3	3,349	**3647**
13-Q4	3,028	**3647**
14-Q1	3,054	**3011**

Interpretation - Patient And Business:

The Emergency Department non-admitted, low acuity visits are meeting target volumes.

Actions & Monitoring Underway to Improve Performance:

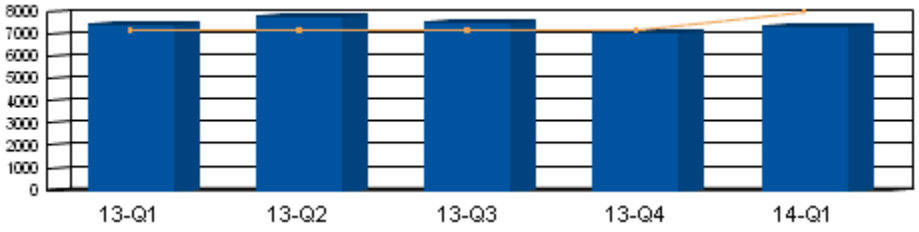
The volume of ED visits in this category have been appropriately decreasing over the past 2 quarters indicating that patients requiring less urgent medical attention are utilizing resources other than the ED.

Definition: DATA: Decision Support COMMENTS: J. Caffin

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, Target 13/14: 9,663

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



	Actual	Target
13-Q1	7,423	**7149**
13-Q2	7,766	**7149**
13-Q3	7,575	**7149**
13-Q4	7,045	**7149**
14-Q1	7,345	**7994**

Interpretation - Patient And Business:

The visits in this category of non-admitted, high acuity make up the greatest proportion of all ED visits. F2014 targets were increased to reflect this. Visits in Q1 this fiscal are in line with the same period last fiscal.

Definition: DATA: Decision Support COMMENTS: Julie Caffin

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, Target 13/14: 31,977

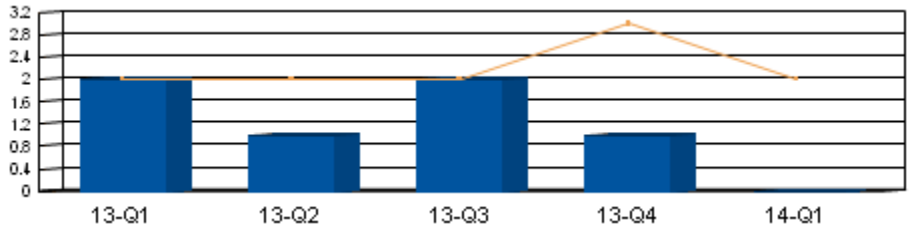
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: Kidney Transplants



	Actual	Target
13-Q1	2	**2**
13-Q2	1	**2**
13-Q3	2	**2**
13-Q4	1	**3**
14-Q1	0	**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:

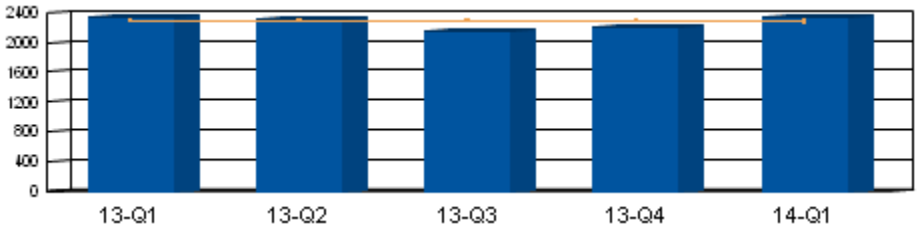
We continue to ready to respond appropriately to organ availability and support the transplantation for patients in our local region.

Definition: DATA: Lana Cassidy COMMENTS: Richard Jewitt

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, Target 13/14: 9 Perf. Corridor: Red <3 Yellow 3 Green >=4

Indicator: OR Cases (Inpatient and Outpatient)



	Actual	Target
13-Q1	2,331	**2286**
13-Q2	2,311	**2286**
13-Q3	2,159	**2286**
13-Q4	2,208	**2286**
14-Q1	2,329	**2282**

Interpretation - Patient And Business:

Improvements with patient activity flow in the post op recovery phase continues to support targets in completed OR cases.

Actions & Monitoring Underway to Improve Performance:

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

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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, Target 13/14: 9,127

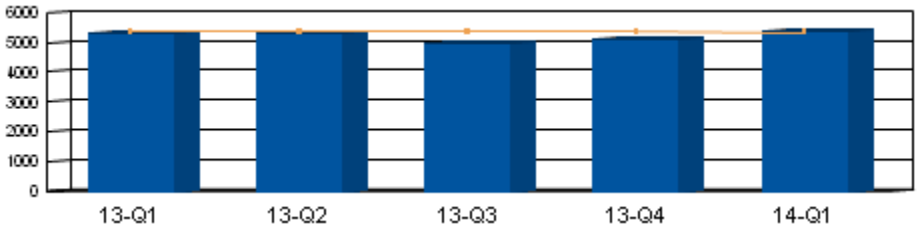
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

Regional Protocols for targeted patient populations are in place and reflect KGH's role

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
13-Q1	5,294	**5345**
13-Q2	5,332	**5345**
13-Q3	5,004	**5345**
13-Q4	5,114	**5345**
14-Q1	5,390	**5332**

Interpretation - Patient And Business:

Improvements with patient activity flow in the post op recovery phase continues to support targets in completed OR hours.

Actions & Monitoring Underway to Improve Performance:

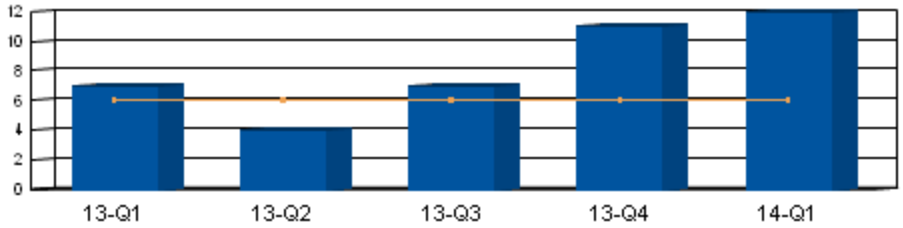
SPA program management and program council continue to monitor OR hours and inpatient/outpatient case volumes.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen

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, Target 13/14: 21,329

Indicator: Stem Cell Transplants



	Actual	Target
13-Q1	7	**6**
13-Q2	4	**6**
13-Q3	7	**6**
13-Q4	11	**6**
14-Q1	12	**6**

Interpretation - Patient And Business:

At the end of Q1 F14, KGH performed 12 stem cell transplants.

Definition: DATA: Lyndsay Richardson COMMENTS: Brenda Carter

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, Target 13/14: 25 Perf. Corridor: Red <21 Yellow 21-24 Green >=25

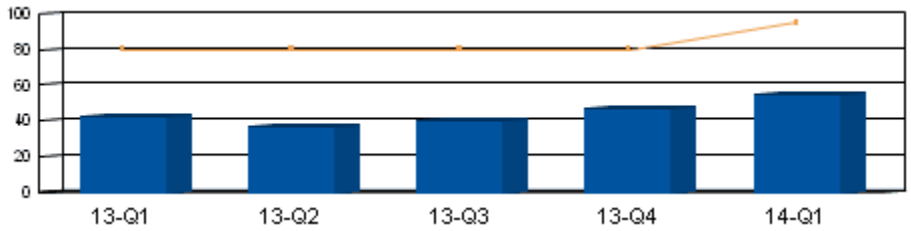
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

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

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



	Actual	Target
13-Q1	42	**80**
13-Q2	37	**80**
13-Q3	40	**80**
13-Q4	47	**80**
14-Q1	55	**95**

Interpretation - Patient And Business:

First quarter results of 55% represent an 8% gain over the previous quarter. Another 10% were completed over the 72 hour target but within 120 hours. Overall chart deficiencies remain within target and continue to support timely data submissions.

Actions & Monitoring Underway to Improve Performance:

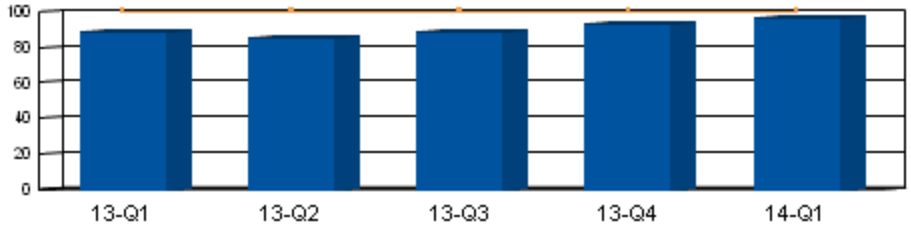
Health Information Services and Medical Administration continue to sanction as per policy. The Joint Quality and Utilization Improvement Committee (JQUIC) will focus on analyzing and interpreting the department/physician performance data to identify strategies to improve performance.

Definition: DATA: Debbie Sapp COMMENTS: Dr. David Zelt

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%, Target 13/14: 95% Perf. Corridor: Red <75% Yellow 75%-85% Green >=85%

Indicator: Percent of Contracted Volumes Achieved



	Actual	Target
13-Q1	89	**100**
13-Q2	85	**100**
13-Q3	89	**100**
13-Q4	93	**100**
14-Q1	96	**100**

Interpretation - Patient And Business:

At Q1 96% of contracted volumes were on target. The 6 yellow surgical indicators all occur at the HDH.

Actions & Monitoring Underway to Improve Performance:

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

Definition: COMMENTS: John Lott

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 , Total Joint Revisions and Cancer Surgery Agreement Volumes.

Target: 2012/2013 Target: 100%, Target 13/14: 100% Perf. Corridor Red <70% Yellow 70%-79% Green >=80%

The top opportunities for improvement in staff engagement with KGH are addressed

Green

Strategic Direction	KGH 2015 outcome	Indicator
People (Enabler)	KGH is designated as one of the best places to work	The top two opportunities for improvement are addressed (Employee recognition program, Leader training on engagement and toolkit)
	Staff are engaged in all aspects of our quality, safety and service improvement initiatives	

Improvement Priorities
Establish employee and physician engagement action plans at unit, program, department levels
Implement leadership development program

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

We are trending green for the top two opportunities for improvement indicators. Other indicators such as sick time indicates that June had the lowest sick time in the last year. CUPE's sick time is the lowest in 12 years. There are fewer full-time employees in the Attendance Program (14% decrease). Of note is that 170 back up child care days will used last year and the Wellness Centre averages 25 visits a day.

2. What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone? (Name the tactic and describe the status)

Employee Engagement Survey completed with 65% participation rate (Phase 1). Plan developed for Phases 2 and 3 of the Engagement Initiative. This includes delivery of leading for engagement training Benchmarking completed regarding best practices on recognition program to formulate recommendations for a revamped KGH program. Addition of over 250 online leadership modules was launched on the Learning Management System. Effective Team Leadership Training pilot with 12 leaders.

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

We are on track to meet the milestone by year end.

4. What new tactics are planned to ensure this milestone is met?

Briefing note regarding revamped recognition program drafted for review by senior leadership. Participation in the CAHO hospitals' pilot for leadership mentoring across the province. Presentation of engagement survey results to the senior leadership is planned for mid-August in conjunction with a workshop on leading for engagement. Schedule has been sent to applicable leaders to attend September sessions to receive survey results and learn how to interpret results. Mandatory Leadership Development Days have been advertised for the fall. In the fall there will be increased focus on mental health and wellness at KGH, with introduction of on site fitness/yoga classes and improvement to the Wellness website. Focus group discussion is planned to look at root causes of overtime.

Kingston General Hospital

MS #07

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
People	The top opportunities for improvement in staff engagement with KGH are addressed	The Top Two Opportunities for Improvement in Staff Engagement are Addressed (Employee Recognition Program, Leader Training on Engagement and Toolkit)	N/A	N/A	N/A	N/A	G	
		Average Sick Days per Eligible Employee Per Year	Y	Y	Y	Y	Y	↓
		Employee Engagement Action Plans Are In Place at All Team Levels	N/A	R	R	Y	G	↑
		Percent Sick Time Hours	Y	Y	R	Y	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

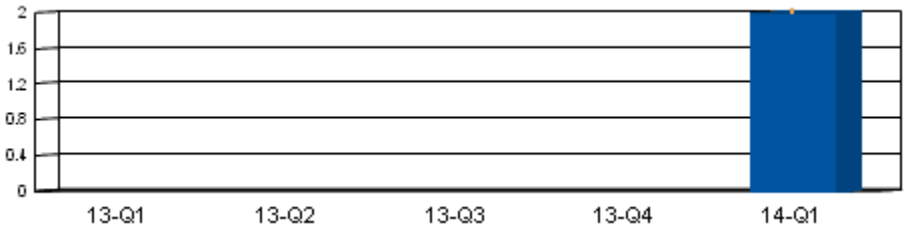
Kingston General Hospital

MS #07

People

The top opportunities for improvement in staff engagement with KGH are addressed

Indicator: The Top Two Opportunities for Improvement in Staff Engagement are Addressed (Employee Recognition Program, Leader Training on Engagement and Toolkit)



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	2	**2**

Interpretation - Patient And Business:

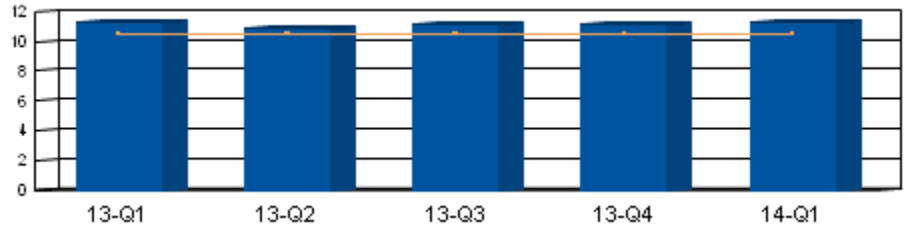
14.8 hours on a goal of 15.

Definition: DATA: PSOE COMMENTS: Carol Sinclair

The top opportunity for improvement in staff engagement is with the implementation of the 2013 leadership development program that includes development of leaders' behavioral competencies, decision making, and improving leaders' visibility and responsiveness. Leaders who participate in this program will by their actions have a positive effect on staff morale and engagement and as a result have improvements that will be realized in the areas of patient safety and the overall patient and staff experiences at KGH.
The second opportunity is to update the KGH employee recognition program. Employees are the key to any successful enterprise and recognition is one of the key drivers of employee engagement influencing such factors as loyalty, satisfaction and ultimately retention and productivity. The current program will be updated to include a social media component and will build on the success of the current mainstay the Team Award of Excellence, by expanding this to focus on additional contributors.

Target: Target 13/14: 2 Perf. Corridor: Red 0 Yellow 1 Green 2

Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
13-Q1	11.3	**10.5**
13-Q2	10.9	**10.5**
13-Q3	11.1	**10.5**
13-Q4	11.1	**10.5**
14-Q1	11.3	**10.5**

Interpretation - Patient And Business:

The average absence days reached 11.34. While this is above where we were at the end of fiscal year, sick time was trending down for the quarter and was significantly lower in June. We also are experiencing the lowest sick time rates for our CUPE group in more than 12 years. 14% fewer employees are in the attendance program.

Actions & Monitoring Underway to Improve Performance:

We are making changes in the Occupational Health, Safety and Wellness department to move to a more functional model with a focus on return to work. Our focus will continue on mental health and wellness with the enhancement of our wellness website, training, fitness offerings and resources. Engagement action plan roll out will assist with the improvements.

Definition: DATA: Ruth Lachapelle COMMENTS: Micki Mulima

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 Target 13/14: 10.5 Perf. Corridor: Red >12 Yellow 10.6-12 Green <=10.5

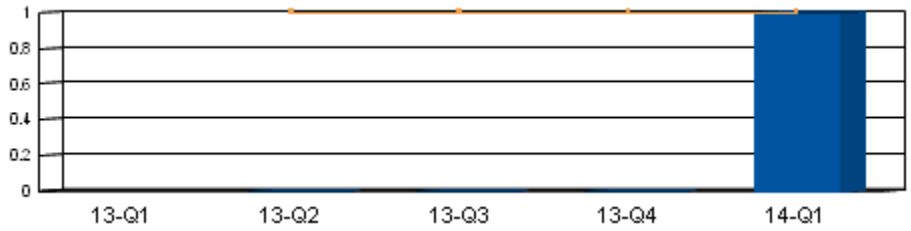
Kingston General Hospital

MS #07

People

The top opportunities for improvement in staff engagement with KGH are addressed

Indicator: Employee Engagement Action Plans Are In Place at All Team Levels



	Actual	Target
13-Q1		
13-Q2	0	**1**
13-Q3	0	**1**
13-Q4	0	**1**
14-Q1	1	**1**

Interpretation - Patient And Business:

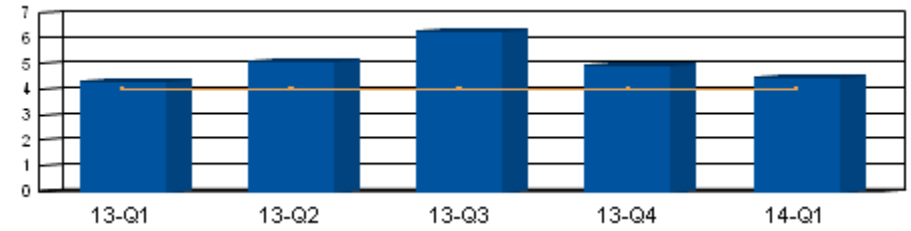
Q1 Survey is complete with 65% response rate. This is higher than the OHA average of 48% and NRC Picker has never seen this before. They believe we did a great job with Promoting the survey and that it was an indication of trust from the employees that we will share results: they want to see the results. It is key /imperative that we share and take action on building a take action toolkit and solutions.

Definition: DATA: PSOE COMMENTS: Carol Sinclair

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 - Survey complete Q2 - Results rec'd/shared with staff Q3 50% of leaders share results/participate in TAG training/develop team action plans Q4 - 100% leaders TAG trained, 100% team Action Plans in place Perf. Corridor: Red Target not met, Yellow Target partially met, Green Target is met

Indicator: Percent Sick Time Hours



	Actual	Target
13-Q1	4.3	**4**
13-Q2	5.1	**4**
13-Q3	6.3	**4**
13-Q4	4.9	**4**
14-Q1	4.5	**4**

Definition: DATA: Lana Cassidy COMMENTS: Micki Mulima

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%, Target 13/14: 4.0% Perf. Corridor: Red >5.00% Yellow 4.01%-5.00% Green <=4.00%

The top sources of preventable harm to staff are addressed

Green

Strategic Direction	KGH 2015 outcome	Indicator
People (Enabler)	**All preventable harm to staff is eliminated**	**Number of preventable harm to staff indicators met**

Improvement Priorities
Reduce the incidence of musculoskeletal injuries, needlestick injuries, violence related (physical abuse) injuries, and staff fall through the implementation of hazard recognition and control

1. **What is our actual performance on the indicator for this milestone as listed above?**
The health and safety scorecard is trending green. 18 indicators were met. The two items in red were managements' response with 21 days to the Joint Health and Safety Committee inspections (645) and respiratory fit testing and training (83%).

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** (Name the tactic and describe the status)
MSI – Team identified, training initiated, review of MSI mandatory training video and trial of new transfer boards are underway.
Needlesticks - A change in team membership was required due to staffing changes, and data analysis is underway.
Violence related injuries – The tactical team is meeting regularly, and a value stream mapping process began. Staff feedback and recruitment of a Patient Experience Advisor for the team was completed.
Falls – The tactical team was formed and trained in LEAN. Data analysis began.
New online Joint Health and Safety Committee inspection form was implemented.

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

4. **What new tactics are planned to ensure this milestone is met?**
Continued work by the tactic teams, Joint Health and Safety Committee activities and follow-up on Safety Incidents by management and the Occupational Health, Safety and Wellness Team.

Kingston General Hospital

MS #08

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
People	The top sources of preventable harm to staff are addressed	Number of Preventable Harm to Staff Indicators are Met	N/A	N/A	N/A	N/A	G
		Number of Health & Safety Scorecard Target Indicators Met	G	R	R	G	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

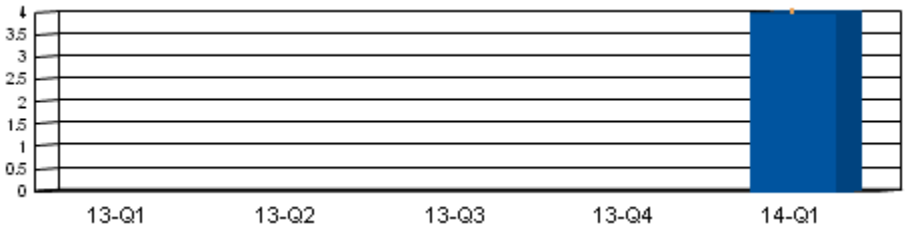
Kingston General Hospital

MS #08

People

The top sources of preventable harm to staff are addressed

Indicator: Number of Preventable Harm to Staff Indicators are Met



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	4	**4**

Interpretation - Patient And Business:

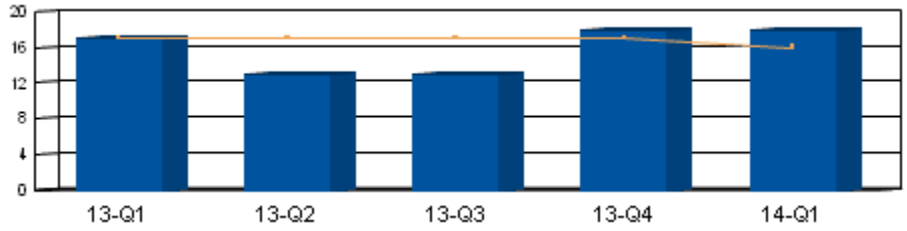
4 tactics on track

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan

Through targeted initiatives that address the top sources of preventable harm to staff, we will create a safer work environment thereby reducing the incidence of staff injury. This will positively impact a number of health and safety outcome measures including our frequency and severity of lost time injury claims, incidence of WSIB healthcare claims, and WSIB NEER costs. Targeted initiatives will focus on identifying and addressing hazards that result in musculoskeletal injuries (MSIs), needlestick injuries (NSIs), violence-related (physical abuse) injuries, and staff falls.

Target: Target 13/14: 4 Perf. Corridor: Red <=1 Yellow 2 Green >=3

Indicator: Number of Health & Safety Scorecard Target Indicators Met



	Actual	Target
13-Q1	17	**17**
13-Q2	13	**17**
13-Q3	13	**17**
13-Q4	18	**17**
14-Q1	18	**16**

Interpretation - Patient And Business:

2 targets in red include: Respirator Fit Testing Compliance and 21 day Management Response to JHSC inspection recommendations.

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan

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: Target 12/13: 17 of 21, Target 13/14: 16 of 20 Perf. Corridor: Red <13 Yellow 13-15 Green <=16

Adoption of continuous improvement principles is increased

Green

Strategic Direction	KGH 2015 outcome	Indicator
Processes (Enabler)	**Continuous improvement environment created with consistent use of LEAN principles**	**Number of improvement priorities using PDSA improvement cycles**

Improvement Priorities
Apply PDSA improvement cycles to all improvement priorities in the annual corporate plan

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

14/24 Improvement Priorities are actively using continuous improvement principles & PDSA improvement cycles. The remaining ten are in the preliminary stages of team development or not yet initiated, but intend to use continuous improvement principles as the work commences in the Plan stage.

2. What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone? (Name the tactic and describe the status)

- During Quarter One our focus was on Planning for the Year. We:
  - Developed the curriculum, training schedule and implementation plan to provide "introduction to continuous improvement training "to all improvement priority team members. Training was scheduled for July and August with over 100 nominees.
  - Introduced a standardized tool for each Executive sponsor to use while working with improvement cycle teams so that they are better able to assess progress to date, the team's next steps and barriers to success as they support the efforts of the teams.
  - Planned for the development of a tool to track the implementation of PDSA cycles over the year and share best practices across the organization.

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

Yes

4. What new tactics are planned to ensure this milestone is met?

- Delivery of "introduction to continuous improvement training" to improvement priority team members.
- Development and pilot of an interactive and searchable PDSA database to track all PDSA's across KGH and enable the sharing of best practices.
- Development of a process to determine with each Executive sponsor how the use of PDSA improvement cycles are working.
- Development of a tool to track progress and measure the effectiveness of the work done.
- Development of a tool to track resources participating on each PDSA to assist with prioritization.

Kingston General Hospital

MS #09

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
Processes	Adoption of continuous improvement principles is increased	Number of Improvement Priorities Using PDSA Improvement Cycles	N/A	N/A	N/A	N/A	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

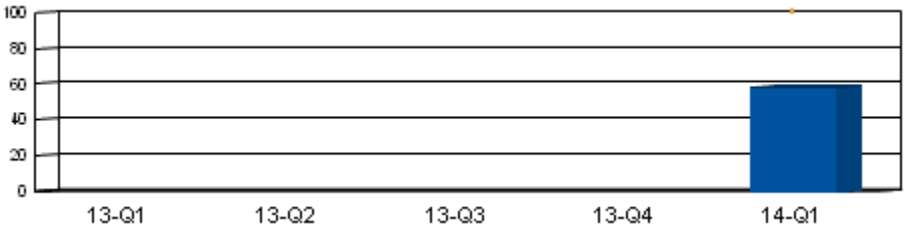
Kingston General Hospital

MS #09

Processes

Adoption of continuous improvement principles is increased

Indicator: Number of Improvement Priorities Using PDSA Improvement Cycles



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	58	**100**

Interpretation - Patient And Business:

A review with all MRPs indicates that all improvement priorities are using continuous improvement methodology and PDSA improvement cycles. MRPs are actively engaging improvement cycle teams in regular updates to understand progress made over short intervals, plans for next steps and any barriers to progress.

Definition: DATA: Jennifer Foster COMMENTS: Jennifer Foster

Leveraging our commitment to continuous quality improvement, all improvement priorities will be achieved through PDSA improvement cycles using lean methodology.

Target: Target 13/14: 100% (24 improvement priorities) Perf. Corridor: Red <38% (<9) Yellow 38%-50% (9-12) Green >50% (>12)

Phase 2 redevelopment is advanced

Yellow

Strategic Direction	KGH 2015 outcome	Indicator
Facilities (Enabler)	Phase 1 redevelopment is complete, Phase 2 construction is underway and KGH has sufficient parking	Stage 2 Approval Status

Improvement Priorities
Support Phase 2 redevelopment by developing a culture of philanthropy at KGH and obtaining approval for stage 2
Improve internal hospital way finding

1. **What is our actual performance on the indicator for this milestone as listed above?**
We made our Stage 1 submission at the end of Fiscal 13 and require Ministry approval to advance to Stage 2. Based on their initial review of our Stage 1 submission, the Ministry has requested additional information related to city wide surgical capacity and plans. More questions will be forthcoming, but as of August 8, no further information has been requested. Basically the Ministry are questioning the number of Operating Rooms contemplated in the plan and the rationale that the status quo should be maintained. As soon as we learned of this request we engaged the SE LHIN to clarify how we will comply with this request as it goes beyond KGH information. Please note the Ministry has not shared any preference in respect to the composition of rooms, just raised the question as a must answer before they will continue review of our Stage 1 submission.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Discussions are ongoing with the SE LHIN, and the SE LHIN is confirming with the Ministry the information required to ensure their question in respect of surgical capacity on the Stage I submission is fully addressed. We expect to receive an update from the SE LHIN at a scheduled meeting in late August.

3. **Are we on track to meet the milestone by year end?**
It is our estimate that the report on the surgical options and rationale for the Phase 2 surgical redevelopment that it will take approximately 3 months to complete. Adding in time for Ministry review of approximately 3 months, it is still possible that we could still have Stage 2 approval before the end of the fiscal year.

   Given the current Ministry focus on fiscal constraint and other priorities, we are concerned about the Ministry capacity to approve capital projects this year.

4. **What new tactics are planned to ensure this milestone is met?**
We are also exploring ways to maintain the momentum of planning, while we await Ministry approval to progress into Stage 2. Recall Stage 2 will take approximately 12 months to complete and includes the detailed functional planning for the project, and the more detailed project costs and time lines, as well as the local share planning. JPO has provided an outline of an approach that the hospital could undertake to complete the functional planning work contemplated in Stage 2 of the Ministry process. This may help lesson the impact of delays in Ministry approval on the total projected time line for Phase 2 Redevelopment if the Ministry is not forthcoming with their approval in the expected time line. As this approach has costs for the hospital, it will not be undertaken without Board approval.

Kingston General Hospital

MS #10

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Facilities	Phase 2 redevelopment is advanced	Quarterly Carpet Removal Targets are Met	Y	G	Y	G	G	↑
	Phase 2 redevelopment functional programming commences	Stage 2 Approval Status	N/A	N/A	N/A	N/A	Y	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

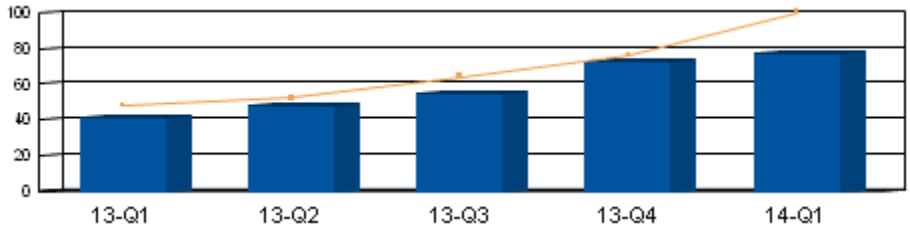
Kingston General Hospital

MS #10

Facilities

Phase 2 redevelopment is advanced

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
13-Q1	41	**48**
13-Q2	48	**52**
13-Q3	55	**64**
13-Q4	73	**76**
14-Q1	77	**100**

Interpretation - Patient And Business:

The Q1 target was 83% completion. Due to a labour strike Kidd 5 was not completed on time, and as such we only achieved a 76.75% completion.

Actions & Monitoring Underway to Improve Performance:

The labour strike ended in mid-July so we are hoping to make up some time, however all remaining completion targets for this fiscal year will likely be below target.

Definition: DATA: Krista Wells-Pearce COMMENTS: Krista Wells-Pearce

The carpet removal plan will be completed this year. Removal targets, based on percent of square footage removed in patient care areas, are as follows: Q1 83%, Q2 96%, Q3 100%, Q4 N/A.

Target: 12/13 Target: 75% (Interim Targets - Q1 - 48%, Q2 - 52%, Q3 - 64, Q4 - 75%)
13/14 Target: 100% Perf. Corridor: Red <90% Yellow 90%-95% Green >95% (Q1 - 83%. Q2 - 96%. Q3 - 100%. Q4 - N/A)

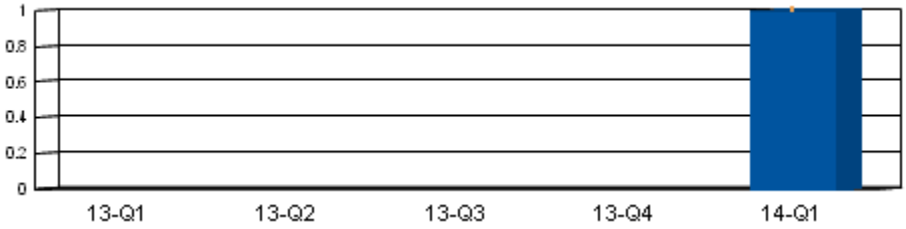
Kingston General Hospital

MS #10

Facilities

Phase 2 redevelopment functional programming commences

Indicator: Stage 2 Approval Status



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

Interpretation - Patient And Business:

A preliminary review meeting was held with the MOHLTC in April. The MOHLTC indicated that approval would likely not be forthcoming before the fall.

Actions & Monitoring Underway to Improve Performance:

We will continue to discuss the project with the MOHLTC and insure they understand the risks associated with our existing buildings and infrastructure. Fundraising efforts continue such that we will have our local share secured in time for the start of construction, expected in Fiscal 2018.

Definition: DATA: Krista Wells-Pearce COMMENTS: Krista Wells-Pearce

The Phase 2 Redevelopment Project plans are being prepared in compliance with the LHIN/MOHLTC Capital Planning Toolkit. The Stage One: Proposal submission was endorsed by the LHIN in 2013.

Q1 - until received - Advocate with MOHLTC for approval to proceed to Stage 2: Functional Programming; and update Programming Work Plan
Q2 – draft transfer agreements for Etherington with Queens University; and local share plan with UHKF.
Upon approval ….next complete quarter
Q..: Complete 75% of Functional Programming; prepare draft local share plan
Next Q Finalize functional program and block diagrams; complete local share plan; finalize land transfer agreements with Queen's University.

February and is currently under review at the MoHLTC. Upon MOHLTC approval of the Stage One Proposal, and their approval to advance to Stage Two; Functional Program process will commence. We would expect the planning schedule shows that Functional Programming will commence in fiscal 2014.

Target: Target 13/14 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes

Strategic technology projects are completed on time and on budget

Green

Strategic Direction	KGH 2015 outcome	Indicator
Technology (Enabler)	**Rapid transmission of information improves care and operational efficiency**	**Number of Strategic Technology Projects on time and on budget**

Improvement Priorities

Focus organizational project resources on strategic technology projects (staff scheduling system, automated drug cabinet project, lab order entry project, phase 3 Emergency Department Information System, participation in regional plan for IT systems)

1. **What is our actual performance on the indicator for this milestone as listed above?**
   All five projects are performing on plan and no issues to report at this time. In Q1 the plan for Regional IT Systems Project passed a major critical approval at SECHEF, achieving approval to advance to preparation of a RFP that is planned to be released in Q3 (a status summary for EMC of all five projects is attached if additional information is required).

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
   To support the Regional IT System the SE LHIN has approved funding in Q2 to support the hiring of a lead to coordinate the development of the seven hospitals documentation required for the RFP. All other projects progressing on plan. However a clinical program request has been made to see if the Automated Drug Cabinet Project could be advanced to complete in fiscal 2014 instead of 2015. the Hospital Capital Committee is reviewing cash flow and the ADC Project Steering Committee is checking other resources to try and accommodate the request. The Drug Cabinet installations to date are being very well received.

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

4. **What new tactics are planned to ensure this milestone is met?**
   Nothing to report at this time.

Kingston General Hospital

MS #11

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Technology	Strategic technology projects are completed on time and on budget	Number of Strategic Technology Projects on Time and on Budget	N/A	N/A	N/A	N/A	G	
		Staff Scheduling and Time Capture Project	N/A	N/A	N/A	N/A	G	
		Automated Medication Dispensing System in Place Throughout Inpatient Units Within the Hospital	G	G	G	G	G	↑
		Implementation of an Order Management System for Labs on All Inpatient Areas (% Completion).	G	G	G	G	G	↑
		Phase 3 of EDIS is Implemented	N/A	N/A	N/A	N/A	G	
		Participation in a Regional Plan for IT Systems	N/A	N/A	N/A	N/A	G	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

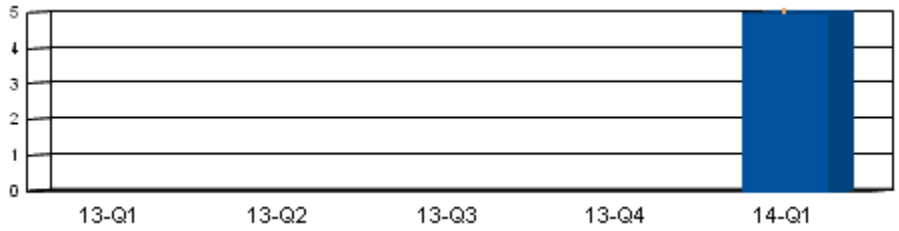
Kingston General Hospital

MS #11

Technology

Strategic technology projects are completed on time and on budget

Indicator: Number of Strategic Technology Projects on Time and on Budget



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	5	5

Interpretation - Patient And Business:

All five strategic technology projects are on time and within budget.

Actions & Monitoring Underway to Improve Performance:

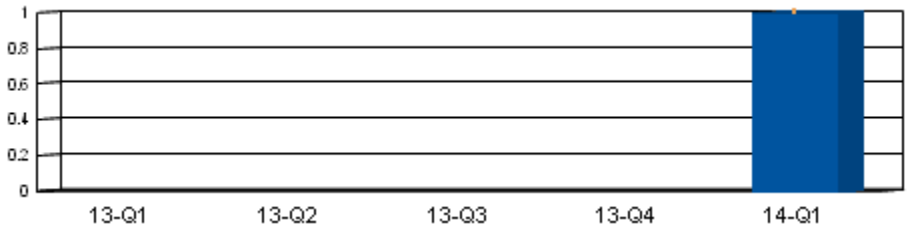
Continue to monitor project delivery via the established steering committees.

Definition: DATA: Troy Jones COMMENTS: Troy Jones

Each of the strategic technology projects (Staff Scheduling System, Automated Drug Cabinets, Lab order Entry, EDIS Phase 3, and Regional IT Planning) will be monitored by a Steering Committee that approves the Project Charter and evaluates progress against a detailed work plan and budget.
The indicator is based on the number of strategic technology projects that are progressing on time and on budget.

Target: Target 13/14: 5 Perf. Corridor: Red <=3 Yellow 4 Green 5

Indicator: Staff Scheduling and Time Capture Project



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	1	1

Interpretation - Patient And Business:

The completed project requirements were signed off by the process owners. External vendors scheduled to begin creating the future state. Steering committee supported proposed realignment of functions and departments to enable the new scheduling and time processes.

Actions & Monitoring Underway to Improve Performance:

Ensure change management and communications resources are in place to support the project timelines. Complete assessment of the appropriate organization design to support the proposed future state.

Definition: COMMENTS: Steve Putman

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 13/14: 1 Perf. Corridor: Red No Yellow N/A Green Yes

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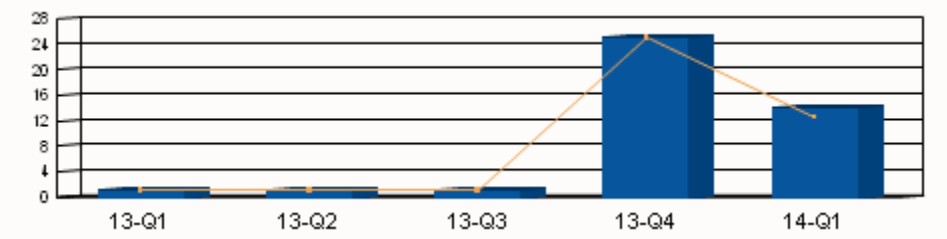
Kingston General Hospital

MS #11

Technology

Strategic technology projects are completed on time and on budget

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



	Actual	Target
13-Q1	1	**1**
13-Q2	1	**1**
13-Q3	1	**1**
13-Q4	25	**25**
14-Q1	14	**12**

Interpretation - Patient And Business:

The installation of cabinets on K3, SPEC; K7 were successfully completed during Q1. Front line staff continues to express positive feedback regarding the product selection, implementation and the clinical benefits.

Actions & Monitoring Underway to Improve Performance:

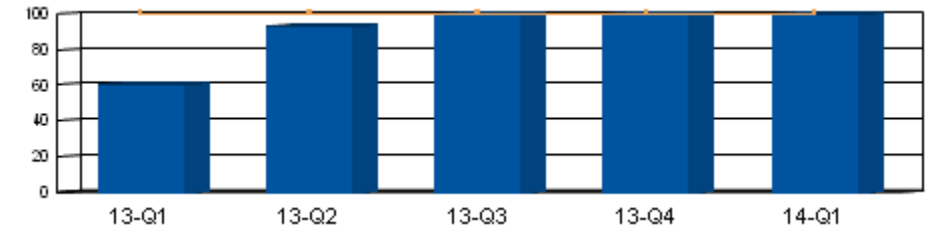
In response to clinical feedback, additional capital has been approved to complete the project this fiscal year. Additional planning has begun to determine if required infrastructure modifications will support the new target date.

Definition: DATA: Alan Smith COMMENTS: Alan Smith

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)
Target 13/14: 50% (Interim Targets: Q1 - 12.5 % Q2 - 25% Q3 - 37.5% Q4 - 50%)

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



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

Interpretation - Patient And Business:

Q1 Renal complete, FAPC planning complete and execution phase underway (project slightly ahead of schedule).

Definition: DATA: Joyce deVette-McPhail COMMENTS: Joyce deVette-McPhail

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 12/13: 100% (all remaining patient areas).
Targets 13/14: Q1 - Renal initiated, FAPC planning complete Q2 - Renal complete, FAPC planning Q3 - FAPC complete Q4 - 100% complete - Maintenance and sustainability

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Kingston General Hospital

MS #11

Technology

Strategic technology projects are completed on time and on budget

Indicator: Phase 3 of EDIS is Implemented

	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	1	1

Interpretation - Patient And Business:

The final step in phase 2 of EDIS implementation was physician documentation which went live on June 17, 2013.

Actions & Monitoring Underway to Improve Performance:

Planning for Phase 3, Computerized Provider Order Entry (CPOE), will start once phase 2 is stabilized (planning for August meeting).

Definition: COMMENTS: Julie Caffin

Computerized Provider Order Entry (CPOE) is the final phase of the EDIS Project. This phase will bring together all aspects of the ER order flow and clinical documentation within EDIS. This will reduce the patient risk and inefficiencies associated with a hybrid paper and electronic documentation environment.
Other benefits of this phase include improved communication between clinicians by using the full functionality of the EDIS system.
The indicator we will be using to measure our success is full implementation of computerized order entry and the close out and the successful hand off of operational tasks associated with the EDIS Project.

Target: Target 13/14: 1 Perf. Corridor: Red No Yellow N/A Green Yes

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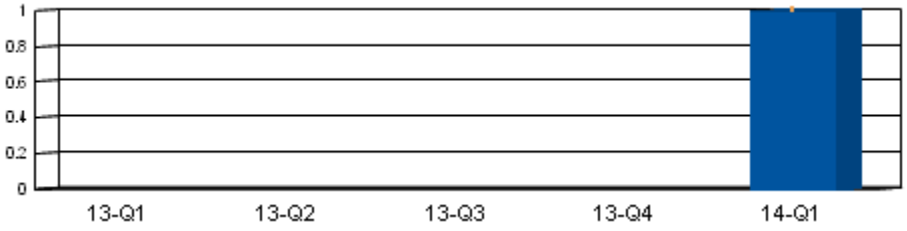
Indicator: Participation in a Regional Plan for IT Systems



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	1	1

Interpretation - Patient And Business:

Support obtained from regional CEOs (SECHEF) to move forward with RFP for a common Hospital Information System (HIS). External funding secured to develop the RFP.

Actions & Monitoring Underway to Improve Performance:

Internal engagement expected to increase in September to support the requirements gathering for the RFP. Continue to monitor regional IT planning project to ensure RFP process meets KGH's needs and timelines.

Definition: DATA: Troy Jones COMMENTS: Troy Jones

The Regional Plan for IT Systems includes, completing an RFP for a common Hospital Information System (HIS) for all seven South East hospitals and establishing the associated regional organizational structure.

Target: Target 13/14: 1

Financial health is sustained

Red

Strategic Direction	KGH 2015 outcome	Indicator
Finances (Enabler)	Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures	Hospital Operations Actual vs. Plan Variance ($000s)

Improvement Priorities
Implement approved clinical and operational efficiencies within the 2013-14 budget
Increase our capital spend to $17.5 million
Prepare the organization to support Health System Funding Reform

1. **What is our actual performance on the indicator for this milestone as listed above?**
At the end of Q1, we had a negative variance to plan of $748,000. This was the result of several areas of pressure including, lower than anticipated patient revenues, higher compensation related to medicine beds, emergency department, and environmental services, and med/surg. supplies. The hospital saw several code gridlock events in the first quarter and is experiencing increased high cost procedures in several areas. All these events contribute to the negative variance.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** In Q1 several initiatives were launched to address the pressures. A series of PDSA reviews were engaged to address Code Gridlock experience and while this work continues we have seen a marked reduction in costs and bed issues in the start of Q2.In addition all portfolios have been engaged in reviewing variances and cost pressures to help ensure we continue to manage the variances.

3. **Are we on track to meet the milestone by year end?**
At the end of July, we have approximately a $200,000 positive variance. While this result is in part due to increased Ministry revenue, we have also seen improvement in the compensation variances and supply costs. Several initiatives have been implemented by Services and Programs to address the negative variances, including additional monitoring of staff schedules and supply procurement and this work continues.

4. **What new tactics are planned to ensure this milestone is met?**
The tactics engaged above will continue throughout the year (Code Gridlock PDSA, and regular Quarterly and Monthly Performance reviews and tactics to address variances). Quarter 1 Review is planned for August 20 and 21.

Kingston General Hospital

MS #12

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Finances	Financial health is sustained	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	R	↓
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	G	G	G	G	Y	↑
		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 ↓

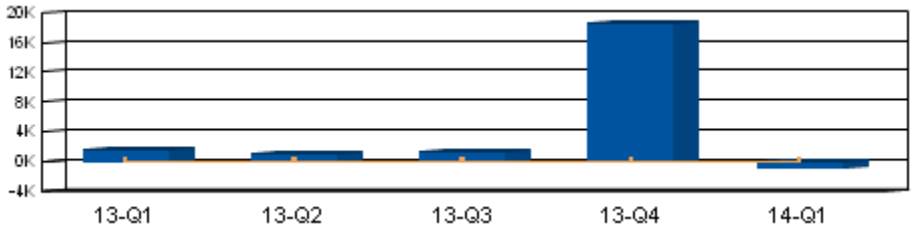
Kingston General Hospital

MS #12

Finances

Financial health is sustained

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



	Actual	Target
13-Q1	1,651	**0**
13-Q2	941	**0**
13-Q3	1,411	**0**
13-Q4	18,555	**0**
14-Q1	-748	**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:

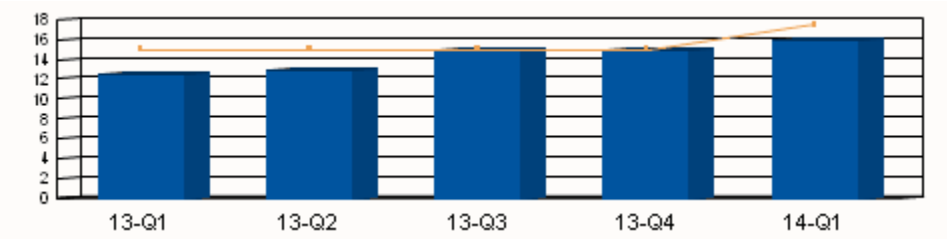
The financial results at the end of Q1 are unfavourable to plan and are mainly attributable to higher than planned compensation and patient care supplies costs in several direct patient care areas and Environmental Services and Diagnostic Imaging. The hospital Executive is reviewing opportunities to enact further operational initiatives which will facilitate the organization to meet the required balanced operating position for this fiscal year.

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan

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, Target 13/14: 0 Perf. Corridor: Red -2% Yellow -1% Green >=0%

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



	Actual	Target
13-Q1	12.5	**15.0**
13-Q2	12.9	**15.0**
13-Q3	15.0	**15.0**
13-Q4	15.0	**15.0**
14-Q1	16.0	**17.5**

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 targeted $17.5 million for capacity for investment in capital for fiscal 2014 including the support from the Ministry Health Infrastructure Renewal Fund, the Kingston General Hospital Foundation, and the Kingston General Hospital Auxiliary. Due to a lower than anticipated reduction of HBAM funding for this year, the capital capacity has increased to $16.0 million as at the end of Q1.

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan

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, Target 13/14: $17.5M Perf. Corridor: Red <$15M yellow $15M-$17.4M Green >=$17.5M

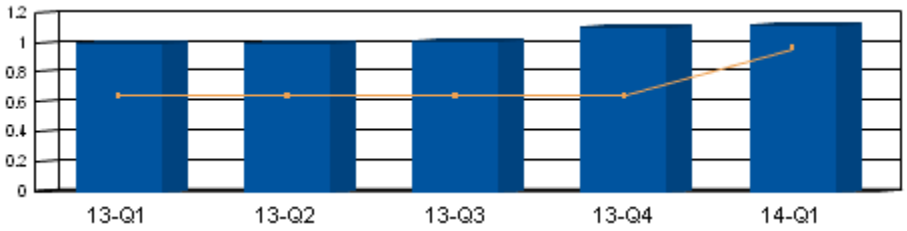
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Current Ratio



	Actual	Target
13-Q1	0.99	**0.64**
13-Q2	0.99	**0.64**
13-Q3	1.01	**0.64**
13-Q4	1.10	**0.64**
14-Q1	1.12	**0.96**

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 current ratio as at the end of Q1 is essentially unchanged from the prior year ending position and slightly exceeds the total year budgeted performance.

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan

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, Target 13/14: 0.96 Perf. Corridor: Red <0.6 Yellow 0.6-0.79 Green 0.8 - 2.0 or +- 10% of neg. target

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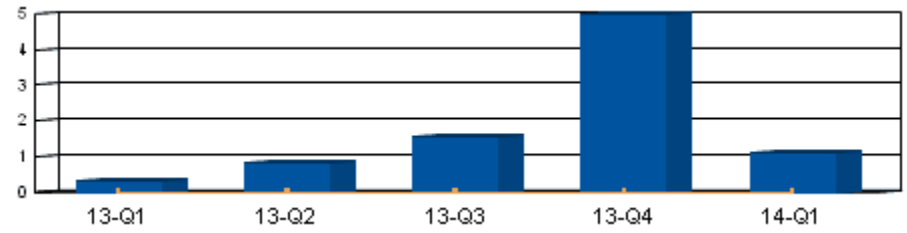
Indicator: Total Margin



	Actual	Target
13-Q1	0.33	**0**
13-Q2	0.80	**0**
13-Q3	1.55	**0**
13-Q4	4.97	**0**
14-Q1	1.08	**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:

KGH is working towards a balanced operating position for fiscal 2014. At the end of Q1, the total margin is within the Ministry acceptable range (0 - 3%). The operating results for this period are however unfavourable to budget. This variance is reflected in the Hospital Operations Actual vs Plan Variance indicator.

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan

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, Target 13/14: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

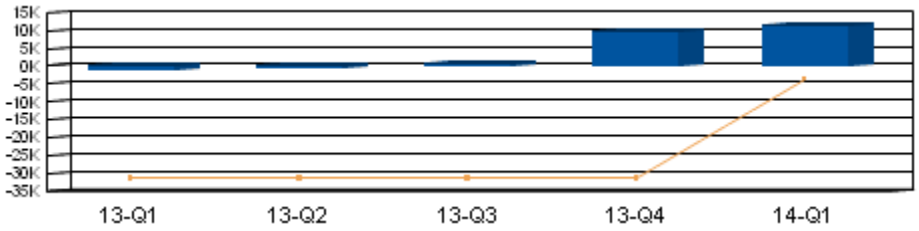
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Working Capital ($000's)



	Actual	Target
13-Q1	-601	**-31500**
13-Q2	-481	**-31500**
13-Q3	610	**-31500**
13-Q4	10,071	**-31500**
14-Q1	11,321	**-3706**

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 hospital working capital position as at the end of Q1 is essentially unchanged from the prior year ending position and slightly exceeds the total year budgeted performance.

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan

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), Target 13/14: ($4M) Perf. Corridor: Red <$-4M Yellow $-4M to $0 Green $0

KGH communication standards are implemented across the organization

Green

Strategic Direction	KGH 2015 outcome	Indicator
Communication (Enabler)	**We continue to engage and report openly and regularly on our progress**	**Percent of leaders who complete communication training**

Improvement Priorities
Build communication capacity with KGH leaders
Implement external engagement plan

1. **What is our actual performance on the indicator for this milestone as listed above?**
Our Q1 target for this indicator was to develop a plan and the framework for delivering a training program to build communication capacity with KGH leaders. This was achieved in Q1.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** (Name the tactic and describe the status)
The capacity building initiative must be based on a thorough understanding of what the organization requires of its leaders from a communicaiton perspective and how equipped our leaders feel they are to fulfill those requirements. In Q1 we:
- Planned a short consultation process to help assess leaders' communication knowledge and skill development requirements as part of the overall plan for delivering the training program.
- Began the process of identifying specific learning and development needs by conducting a "think tank on high performance leadership communications" on April 24, 2012.

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

4. **What new tactics are planned to ensure this milestone is met?**
IP1.
- We will continue to seek input from leaders and staff as we conduct a more detailed communications audit to examine the overarching communications sytem in our organizzation, with emphasis on leader/manager communication with front-line staff.
- We are working closely with PSOE to validate the integrity of our plans and seek assistance with the development of our training program and its integration with the leadership development program.

IP2.
- We will develop a KGH Connect event plan for our 175th Anniversary celebration, which will be designed to engage key community stakeholders.
- KGH website renewal plans are being finalized in preparation for an RFP, which will be issued in Q2.

Kingston General Hospital

MS #13

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
Communication	KGH communication standards are consistently implemented across the organization	Percent of Leaders Who Complete Communication Training	N/A	N/A	N/A	N/A	G
		Staff Satisfaction with Communication at KGH Will Improve by 20% Based on Responses to the Statement I am Satisfied with Communications in this Organization	R	R	R	Y	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

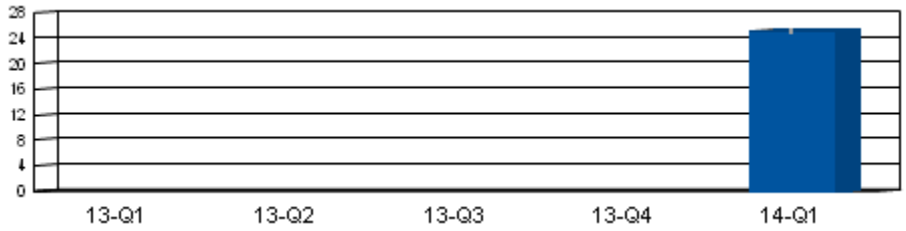
Kingston General Hospital

MS #13

Communication

KGH communication standards are consistently implemented across the organization

Indicator: Percent of Leaders Who Complete Communication Training



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	25	**25**

Interpretation - Patient And Business:

A plan and the framework for how we will address communications training for the KGH Leadership group has been developed and steps have already been taken to further our understanding of what the organization requires of its leaders from a communication perspective and how equipped our leaders feel they are to fulfill those requirements. We began the process of identifying specific learning and development needs by conducting a "think tank on high performance leadership communications", which took place on April 24, 2013. This session helped us to develop the KGH Communications Standards; the criteria by which we measure the appropriateness of every communication activity we undertake. In Q2 we will continue to seek input from leaders and staff as we conduct a more detailed communications audit. The audit will look at the overarching communications system in our organization, with emphasis on leader/manager communication with front-line staff. We will continue to work closely with People Services to validated the integrity of our plan and seek assistance with the development of our training program and its integration within the hospital's 2013-14 leadership development program.

Definition: COMMENTS: Helen Simeon

A plan and the framework for how we will address communications training for the KGH Leadership group has been developed and steps have already been taken to further our understanding of what the organization requires of its leaders from a communication perspective and how equipped our leaders feel they are to fulfill those requirements. We began the process of identifying specific learning and development needs by conducting a “think tank on high performance leadership communications”, which took place on April 24, 2013. This session helped us to develop the KGH Communications Standards; the criteria by which we measure the appropriateness of every communication activity we undertake. In Q2 we will continue to seek input from leaders and staff as we conduct a more detailed communications audit. The audit will look at the overarching communications system in our organization, with emphasis on leader/manager communication with front-line staff. We will continue to work closely with People Services to validated the integrity of our plan and seek assistance with the development of our training program and its integration within the hospital’s 2013-14 leadership development program.

Target: Target 13/14: 100% Perf. Corridor: Red <70% Yellow 70%-79% Green >=80%

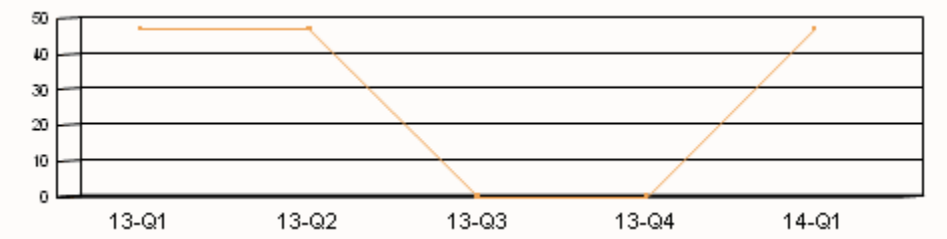
Kingston General Hospital

MS #13

Communication

KGH communication standards are consistently implemented across the organization

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
13-Q1		47
13-Q2		47
13-Q3		0
13-Q4		0
14-Q1		47

Interpretation - Patient And Business:

The Worklife Pulse survey was not implemented in light of the proposed Q1- 2013-14 Employee and Physician Engagement Survey. Therefore, results to measure this indicator are not available. We will measure staff satisfaction with communications at KGH through the 2013 Employee and Physician Engagement Survey.

Actions & Monitoring Underway to Improve Performance:

A question to measure employee communications satisfaction was included on the Employee Engagement Survey. The question was designed to measure the effectiveness of our current communications vehicles and employee preference. Information gathered will inform the design of our internal communications programs.

Definition: DATA: Helen Simeon COMMENTS: Helen Simeon

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%, 13/14 Target: 47% Perf. Corridor Red <37% Yellow 37%- 46% Green >=47%

Kingston General Hospital

2014 Strategy Report

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities	Percent Improvement Priorities with Patient Experience Advisors Engaged	N/A	N/A	N/A	N/A	G	
	The top sources of preventable harm to patients are addressed	Number of Preventable Harm to Patient Indicators Met	N/A	N/A	N/A	N/A	Y	
	The top sources of GRIDLOCK are addressed.	Percent of Recommendations Completed as per Incident Review Triggered by Code GRIDLOCK - (QIP)	N/A	N/A	N/A	N/A	Y	
Bring to life new models of interprofessional care and education	Patient and family-centered care standards are consistently demonstrated throughout KGH	Percent Adoption of Patient and Family Centered Care Standards - (QIP)	N/A	N/A	N/A	N/A	G	
Cultivate patient oriented research	Externally funded research at KGH has increased to 45%	4% Increase of Externally Funded Research Dollars at KGH	N/A	G	G	G	G	↑
Increase our focus on complex-acute and specialty care	Regional Protocols for targeted patient populations are in place and reflect KGH's role	A Protocol to Manage Each Improvement Priority is Adopted	N/A	N/A	N/A	N/A	Y	
People	The top opportunities for improvement in staff engagement with KGH are addressed	The Top Two Opportunities for Improvement in Staff Engagement are Addressed (Employee Recognition Program, Leader Training on Engagement and Toolkit)	N/A	N/A	N/A	N/A	G	
	The top sources of preventable harm to staff are addressed	Number of Preventable Harm to Staff Indicators are Met	N/A	N/A	N/A	N/A	G	
Processes	Adoption of continuous improvement principles is increased	Number of Improvement Priorities Using PDSA Improvement Cycles	N/A	N/A	N/A	N/A	G	
Facilities	Phase 2 redevelopment functional programming commences	Stage 2 Approval Status	N/A	N/A	N/A	N/A	Y	
Technology	Strategic technology projects are completed on time and on budget	Number of Strategic Technology Projects on Time and on Budget	N/A	N/A	N/A	N/A	G	
Finances	Financial health is sustained	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	G	R	↓
Communication	KGH communication standards are consistently implemented across the organization	Percent of Leaders Who Complete Communication Training	N/A	N/A	N/A	N/A	G	

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

2014 QIP

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities	Overall Acute Care Patient Satisfaction (%) - (QIP)	G	G	G	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%) - (QIP)	G	G	G	G	N/A	↑
	The top sources of preventable harm to patients are addressed	Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)	N/A	N/A	N/A	N/A	Y	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	R	R	R	R	R	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days - (QIP)	Y	G	Y	G	Y	↑
		Hand Hygiene Compliance - (QIP)	Y	Y	G	Y	Y	↓
		Percent of Recommendations Completed as per Critical Incident Review Triggered by Mortality Within 5 Days of Major Surgery - (QIP)	N/A	N/A	N/A	N/A	N/A	
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data - (QIP)	R	R	N/A	N/A	N/A	
	The top sources of GRIDLOCK are addressed.	Percent of Recommendations Completed as per Incident Review Triggered by Code GRIDLOCK - (QIP)	N/A	N/A	N/A	N/A	Y	
Bring to life new models of interprofessional care and education	Patient and family-centered care standards are consistently demonstrated throughout KGH	Percent Adoption of Patient and Family Centered Care Standards - (QIP)	N/A	N/A	N/A	N/A	G	
Increase our focus on complex-acute and specialty care	Regional Protocols for targeted patient populations are in place and reflect KGH's role	Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile - (QIP)	R	Y	G	G	R	↓
		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 Q1 F2013-14

			13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
Health and Safety	Health & Safety	OHS - JHSC Health & Safety Inspections Completed	G	G	G	G	G
		OHS - 21 Day Response to JHSC Identified Hazards	R	R	R	Y	R
		OHS - Management Inspection Program	R	R	R	G	G
		OHS - Respirator Fit Testing & Training Compliance	R	R	Y	Y	R
		OHS - WSIB NEER Performance Index - 2009	Y	Y	Y	Y	Y
		OHS - WSIB NEER Performance Index - 2010	G	G	G	G	G
		OHS - WSIB NEER Performance Index - 2011	G	G	G	G	G
		OHS - WSIB NEER Performance Index - 2012	N/A	N/A	G	G	G
		OHS - Incident Investigations Complete	R	R	R	R	Y
		OHS - Lost Time Severity Rate (Days Lost/100 Workers)	G	G	G	G	Y
		OHS - Needlestick Injuries (NSI's) Only	Y	R	R	R	G
		OHS - Total MSI Incidents	Y	R	R	Y	Y
		OHS - MSI Lost Time Injury Claims (LTIs)	G	G	G	G	G
		OHS - MOL Reported Critical Injury Incident	G	G	G	G	G
		OHS - WSIB Lost Time Claims	N/A	N/A	N/A	N/A	G

108	13-Q1	13-Q2	13-Q3	13-Q4	14-Q1
OHS - WSIB Health Care Claims	Y	R	R	R	Y
OHS - Occupational Illness Reported to MOL	Y	G	G	Y	G
OHS - MOL Orders Issued During Site Visit	G	G	R	G	G
OHS - Mandatory Safety Training (Overall Compliance)	Y	Y	Y	Y	Y
OHS - Pre-Placement Health Screening Completed	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

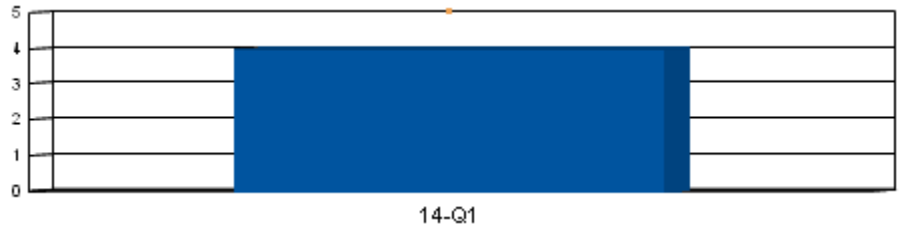
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB Lost Time Claims



	Actual	Target
14-Q1	4	**≤5**

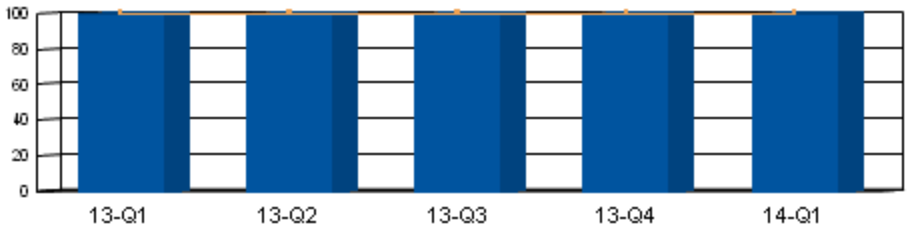
Interpretation - Patient And Business:

2 lost time injuries were related to being struck on head with equipment, 1 was related to a fall and one related to eye infection.

Definition:

Target: Target 2013/14:

Indicator: OHS - JHSC Health & Safety Inspections Completed

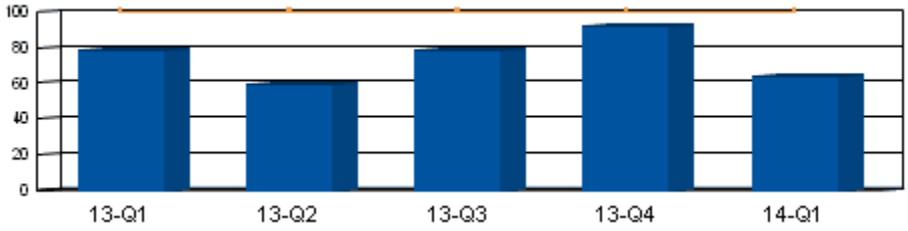


	Actual	Target
13-Q1	100	**100**
13-Q2	100	**100**
13-Q3	100	**100**
13-Q4	100	**100**
14-Q1	100	**100**

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%, Target 2013/14: 100%

Indicator: OHS - 21 Day Response to JHSC Identified Hazards



	Actual	Target
13-Q1	78	**100**
13-Q2	59	**100**
13-Q3	78	**100**
13-Q4	92	**100**
14-Q1	64	**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%, 2013/14 Target: 100%

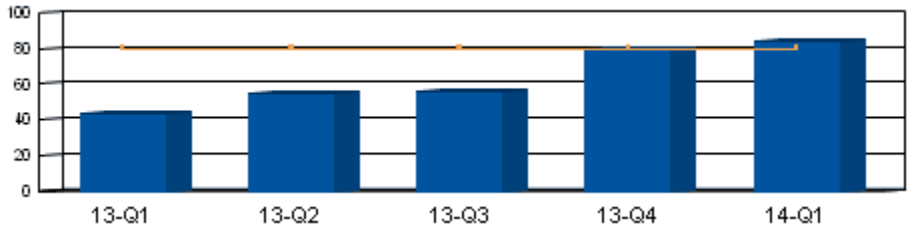
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Management Inspection Program

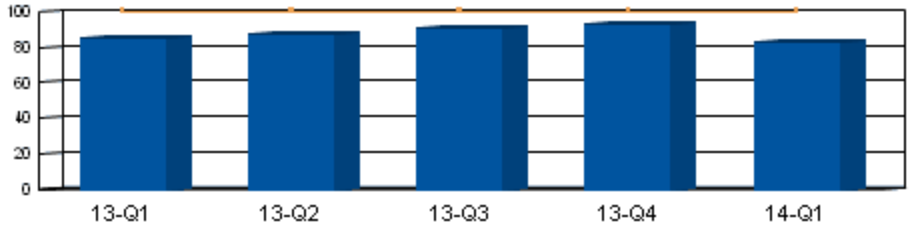


	Actual	Target
13-Q1	44	**80**
13-Q2	55	**80**
13-Q3	56	**80**
13-Q4	80	**80**
14-Q1	84	**80**

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%, Target 2013/14: 80%

Indicator: OHS - Respirator Fit Testing & Training Compliance

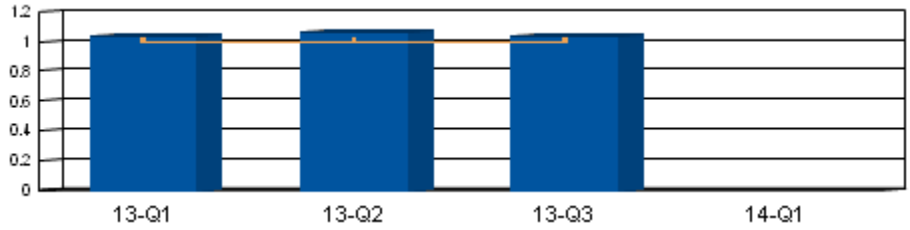


	Actual	Target
13-Q1	85	**100**
13-Q2	87	**100**
13-Q3	91	**100**
13-Q4	93	**100**
14-Q1	83	**100**

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%, Target 2013/14: 100%

Indicator: OHS - WSIB NEER Performance Index - 2009



	Actual	Target
13-Q1	1.04	**1**
13-Q2	1.06	**1**
13-Q3	1.04	**1**
14-Q1	1.03	**1**

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, Target 2013/14: < 1

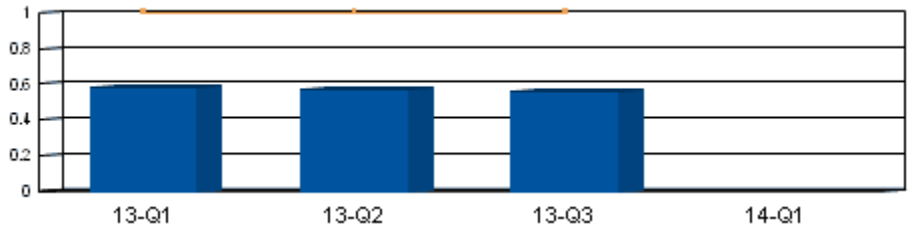
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2010

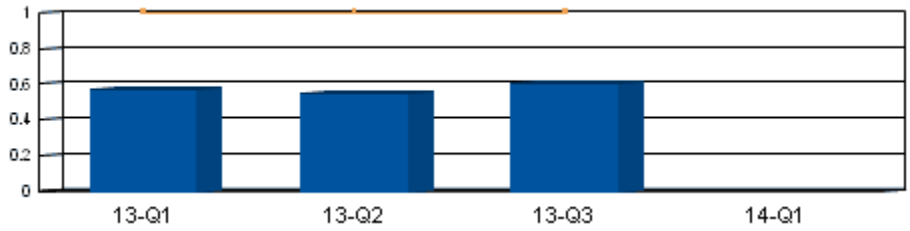


	Actual	Target
13-Q1	0.58	**1**
13-Q2	0.57	**1**
13-Q3	0.56	**1**
14-Q1	0.52	**1**

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, Target 2013/14: < 1

Indicator: OHS - WSIB NEER Performance Index - 2011

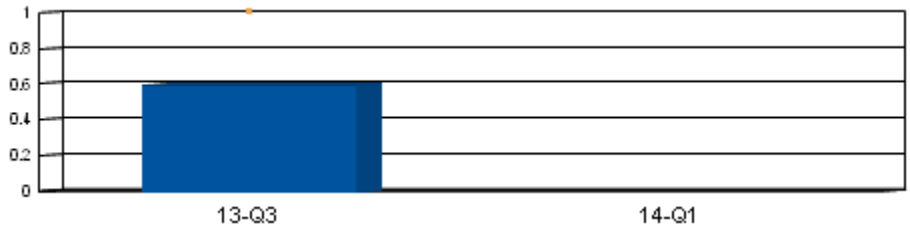


	Actual	Target
13-Q1	0.57	**1**
13-Q2	0.55	**1**
13-Q3	0.60	**1**
14-Q1	0.77	**1**

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, Target 2013/14: < 1

Indicator: OHS - WSIB NEER Performance Index - 2012



	Actual	Target
13-Q3	0.59	**1**
14-Q1	0.26	**1**

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, Target 2013/14: < 1

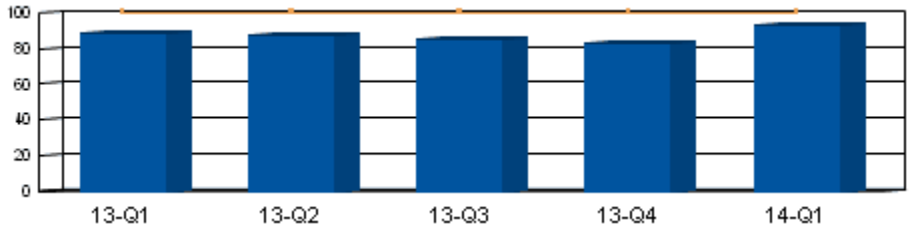
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Incident Investigations Complete

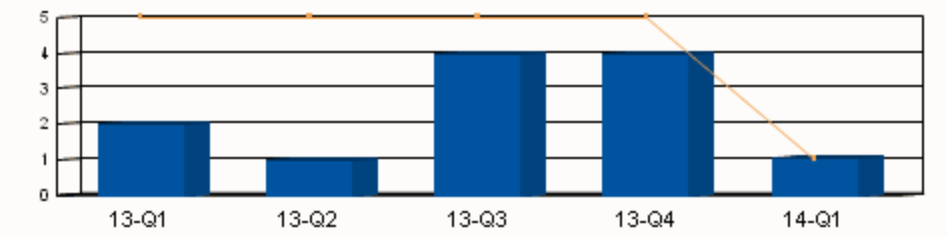


	Actual	Target
13-Q1	89	**100**
13-Q2	87	**100**
13-Q3	85	**100**
13-Q4	83	**100**
14-Q1	93	**100**

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%, Target 2013/14: 100%

Indicator: OHS - Lost Time Severity Rate (Days Lost/100 Workers)



	Actual	Target
13-Q1		
13-Q2		
13-Q3		
13-Q4		
14-Q1	1.03	**≤1**

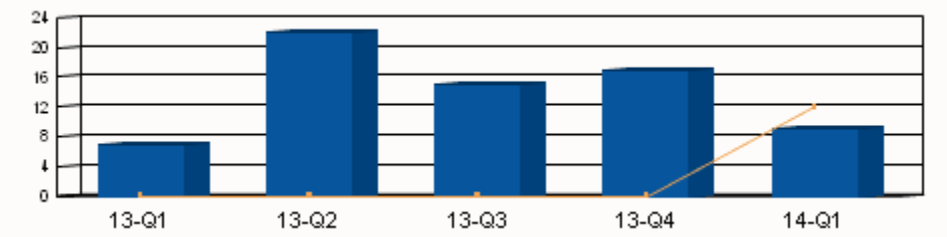
Interpretation - Patient And Business:

Total days lost this quarter were 35

Definition: Rate 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 2013/14: 0

Indicator: OHS - Needlestick Injuries (NSI's) Only



	Actual	Target
13-Q1	7	**0**
13-Q2	22	**0**
13-Q3	15	**0**
13-Q4	17	**0**
14-Q1	9	**≤ 12**

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

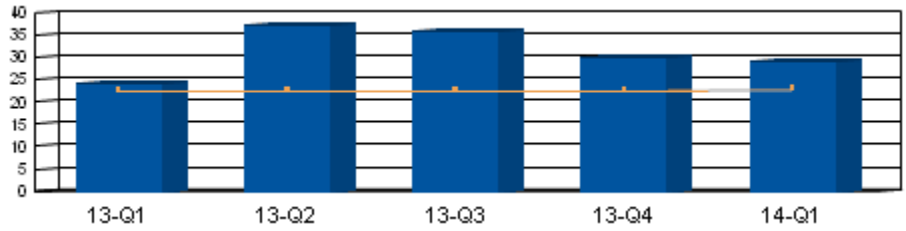
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Total MSI Incidents



	Actual	Target
13-Q1	24	< 23
13-Q2	37	<23
13-Q3	36	<23
13-Q4	30	<23
14-Q1	29	<23

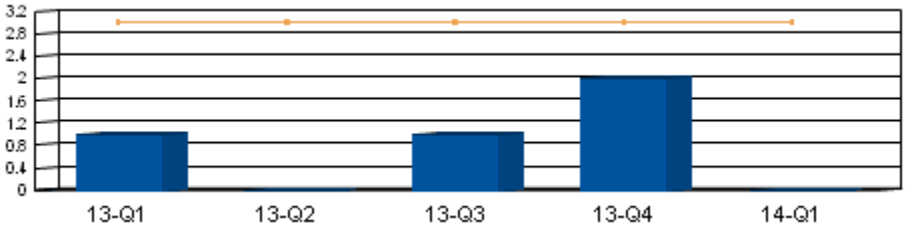
Interpretation - Patient And Business:

44% related to patient handling and 66% related to all other causes. Highest incidences occurred in SPA, Environmental Services, and Critical Care.

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

Target: 2012/13 Target: <=90. 2013/14: <=90

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

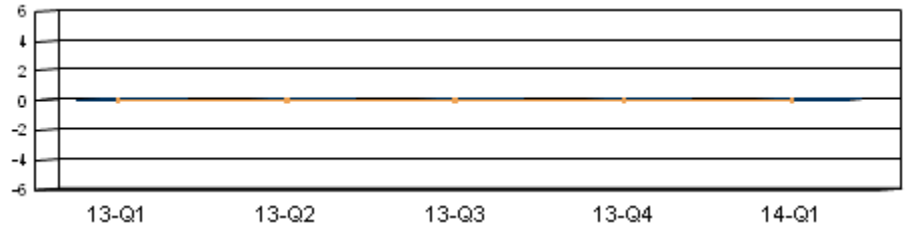


	Actual	Target
13-Q1	1	<3
13-Q2	0	<3
13-Q3	1	<3
13-Q4	2	<3
14-Q1	0	<3

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

Target: Target 2012/13: 10, Target 2013/14: 10

Indicator: OHS - MOL Reported Critical Injury Incident



	Actual	Target
13-Q1	0	0
13-Q2	0	0
13-Q3	0	0
13-Q4	0	0
14-Q1	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, Target 2013/14: 0

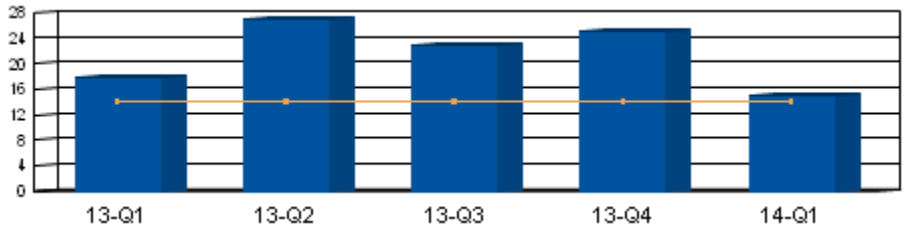
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB Health Care Claims



	Actual	Target
13-Q1	18	**≤ 14**
13-Q2	27	**≤14**
13-Q3	23	**≤14**
13-Q4	25	**≤14**
14-Q1	15	**≤14**

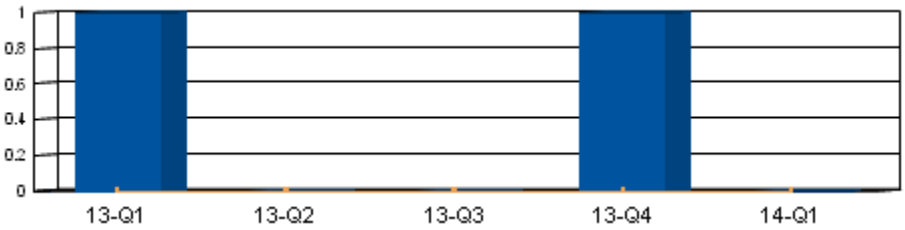
Interpretation - Patient And Business:

30% of HC claims occurred in SPA program and 27% in Medicine Program.
5 were related to struck/contact by injuries, 3 were related to infectious exposures, MSI-other 3, MSI patient handling 3, Physical Abuse 1

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, Target 2013/14: <= 54

Indicator: OHS - Occupational Illness Reported to MOL

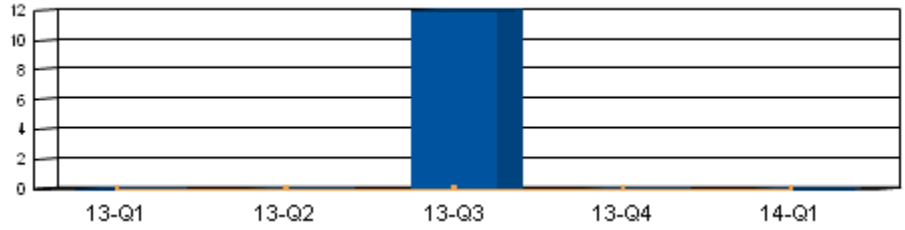


	Actual	Target
13-Q1	1	**0**
13-Q2	0	**0**
13-Q3	0	**0**
13-Q4	1	**0**
14-Q1	0	**0**

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:

Indicator: OHS - MOL Orders Issued During Site Visit



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

Interpretation - Patient And Business:

No MOL visits in Q1.

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, 2013/14 Target: 0

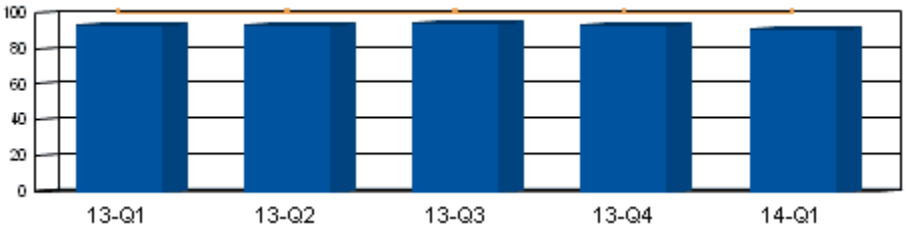
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Mandatory Safety Training (Overall Compliance)

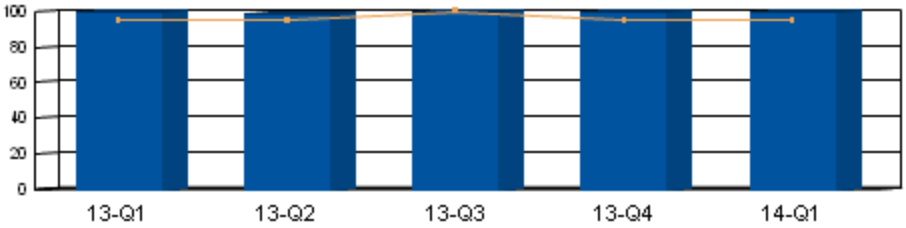


	Actual	Target
13-Q1	93	**100**
13-Q2	93	**100**
13-Q3	94	**100**
13-Q4	93	**100**
14-Q1	91	**100**

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 - Pre-Placement Health Screening Completed



	Actual	Target
13-Q1	100	**95**
13-Q2	99	**95**
13-Q3	100	**100**
13-Q4	100	**95**
14-Q1	100	**95**

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

Target: 2012/13 Target: 95%, 2013/14 Target: 95%
