fiscal 2013-2014 **Q2**

2nd quarter ended September 30, 2013

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

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Master Performance Report
Q2 Fiscal 2013 - 2014

Strategic Direction 1

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

Milestone 1: KGH Experience Advisors are trained and participate in the achievement of all improvement priorities **Page 7**

- Percent improvement priorities with Patient Experience Advisors Engaged
- Overall, how would you rate the care you received at the hospital?
- Percent of patients who answer “definitely yes” to the NRC Picker question “Would you recommend this hospital to your friends and family?”
- Percent of patients who respond “satisfied” to food patient discharge survey
- Overall Acute Care Patient Satisfaction (%)
- Overall Emergency Care Patient Satisfaction (%)

Milestone 2: The top sources of preventable harm to patients are addressed **Page 12**

- Number of preventable harm to patient indicators met
- Reduce the top 3 errors associated with specimen collection
- Number of new cases of hospital acquired infection
- Reduce the top 3 errors associated with medical fluid events
- Achieve zero patient falls in level 3 and level 4 categories (QIP)
- Number of Quality Improvement Plan goals for change met
- All three phases of the Surgical Safety Checklist are performed (Briefing, Time Out, and Debriefing)
- Surgical Site Infection (SSI) prevention
- Anti-biotics dispensed quarterly to ED and admitted patients per 1000 patient days (QIP)
- C-Difficile (Reported Monthly)
- C-Difficile (Reported Quarterly)
- Central Line Bloodstream Infections
- MRSA (Methicillin-resistant Staphylococcus Aureus)
- Ventilator Associated Pneumonia
- VRE (Vancomycin-resistant Enterococcus)
- External Environmental Audits by Westech
- Hand Hygiene Compliance (QIP)
- Hospital Standardized Mortality Rate (HSMR)
- Percent of recommendations completed as per critical incident review triggered by Mortality within 5 days of major surgery (QIP)
- Percent mortality reviews completed with quarterly review of record-level HSMR data (QIP)
- Percent of patients responding “satisfied” to the KGH Environmental Patient Discharge Survey

- 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

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- Percent of recommendations completed as per incident review triggered by Code GRIDLOCK (QIP)
- Percent of clinical services meeting or exceeding 90th percentile wait time targets (excluding cancer surgery)
- All cancer surgery wait time – 90th percentile wait time (days)
- Number of Cancer Care Ontario Access to Care contract indicators met (radiation/chemotherapy)
- Percent of Cancer Care Ontario Access to Surgical Care contract indicators met
- Radiation Wait time (referral-consult) percent seen within 14 days
- Percent of total surgical wait times meeting or exceeding 90th percentile wait time targets
- All Paediatric surgery – 90th percentile wait time (days)
- Cardiac Bypass Surgery – 90th percentile wait time (days)
- Cardiac Coronary Angiography – 90th percentile wait time (days)
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- Percent ALC days
- Overall – Acute average length of stay days (based on HSAA)
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- Number of inpatient by program floor assignment patient days within budget
- Reduce the number of avoidable admissions
- Total inpatient admissions
- Total inpatient weighted cases
- 90th percentile ED wait time – all admitted patients – Hrs (QIP)
- Percent of patients admitted (from the Emergency Department) within a wait time target of <8hrs
- Patients admitted from the Emergency Department (ED) with complex conditions – 90th percentile wait time (hrs)
- Percent of non-admitted low acuity patients (CTAS 4&5) treated within a wait time Target of <4hrs
- Percent of non-admitted high acuity patients treated within a wait time target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)
- Non-admitted patients with minor or uncomplicated conditions in the Emergency Department (ED) – 90th percentile wait time (Hrs)
- Percent of wait time contracted volumes achieved

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-

Strategic Direction 3

Cultivate patient oriented research

Milestone 5: Externally funded research at KGH has increased to 45% on budget **Page 63**

- 4% increase of externally funded research dollars at KGH
- Active clinical trials
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Strategic Direction 4

Increase our focus on complex-acute and specialty care

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- A protocol to manage each improvement priority is adopted
- The number of patients waiting for transfer to other facilities is reduced by 50%
- Readmission rate within 30 days for selected CMG's to any facility
- Improvement in KGH 30-day readmission rate as per SE LHIN CMG Profile (QIP)
- QBP (Quality Based Procedure) – COPD
- QBP (Quality Based Procedure) – Heart Failure (CHF)
- QBP (Quality Based Procedure) – Primary Hip & Knee replacement volume
- QBP (Quality Based Procedure) – Stroke
- QBP (Quality Based Procedure) – Vascular
- Ambulatory care volumes
- Cardiac – Angiography volumes
- Cardiac – Angioplasty volumes
- Cardiac – Bypass volumes
- CT hours (wait time strategy allocation)
- MRI hours (wait time strategy allocation)
- 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
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- OR cases (inpatient and outpatient)
- OR hours (inpatient and outpatient)
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Strategic Direction 5 (Enabler)

People

Milestone 7: The top opportunities for improvement in staff engagement with KGH are addressed **Page 84**

- The top two opportunities for improvement in staff engagement are addressed (employee recognition program, leader training on engagement and toolkit)
- Average sick days per eligible employee per year
- Employee engagement action plans are in place at all team levels
- Percent sick time hours

Milestone 8: The top sources of preventable harm to staff are addressed **Page 89**

- Number of preventable harm to staff indicators are met
- Number of Health & Safety Scorecard target indicators met

Strategic Direction 6 (Enabler)

Processes

Milestone 9: Adoption of continuous improvement principles is increased **Page 92**

- Number of improvement priorities using PDSA improvement cycles

Strategic Direction 7 (Enabler)

Facilities

Milestone 10: Phase 2 redevelopment is advanced **Page 95**

- Quarterly carpet removal targets are met
- Stage 2 approval status

Strategic Direction 8 (Enabler)

Technology

Milestone 11: Strategic technology projects are completed on time and on budget **Page 98**

- Number of strategic technology projects on time and on budget
- Staff scheduling and time capture project
- Automated medication dispensing system in place throughout inpatient units within the hospital
- Implementation of an order management system for labs on all inpatient areas (% completion)
- Phase 3 of EDIS is implemented
- Participation in a regional plan for IT systems

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Strategic Direction 9 (Enabler)

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- Current ratio
- Total Margin
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Strategic Direction 10 (Enabler)

Communication

Milestone 13: KGH communication standards are implemented across the organization **Page 108**

- Percent of leaders who complete communication training
- Staff satisfaction with communication at KGH will improve by 20% based on responses to the statement “I am satisfied with communications in this organization”

Strategy Report (SSC) Summary **Page 112**

Quality Improvement Plan (QIP) Summary **Page 113**

Occupational Health and Safety (OHS) Scorecard **Page 114**

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?** Work continues against the plan that was developed to ensure there are advisors who are interested and prepared to be engaged in the teams addressing corporate improvement priorities. Patient Experience Advisors continue to be recruited to be involved as part of CI Teams, and in advance attend an education program specifically developed to support all advisors. The advisors are preferentially included in initiatives aligned to Gridlock and the patient safety initiatives reporting to the QPCC. To date 14 advisors have signed up for the education and expressed interest in involvement in team work, and 11 of the 14 have completed the training. The 11 advisors are presently populating 15 improvement teams associated with Gridlock, Patient Safety and standards for Patient and Family Centred Care. A few specific teams have 2 or 3 advisors. In addition, one advisor was part of the overall Gridlock VSM process prior to the education programming being made available.

   The results of the NRC Picker patient satisfaction surveys Q1 2013/2014 are not yet available.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Having interested advisors prepared to become members of the improvement teams is critical to this milestone. Recruitment continues through the Patient Relations service, word of mouth by staff and current advisors, and by increasing awareness using a brochure that is made available throughout the hospital.

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; recruit advisors to be available to consider and become engaged in project work; support the process to catalogue their work and involvement; celebrate the involvement in the accomplishments of the teams through education events linked to patient safety week, board education, patient - and family-centred care month and media profile of patient- and family- centred care and engagement of advisors in co-designing improvements. It is noted that advisors are part of many improvement initiatives beyond the corporate priorities reporting to QPCC.

Kingston General Hospital

MS #01

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	G	G	
		Overall, How Would You Rate the Care You Received at the Hospital?	G	G	G	N/A	N/A	↑
		Percent of Patients Who Answer "Definitely Yes" to the NRC Picker Question " Would You Recommend this Hospital to Your Friends and Family?"	G	G	G	N/A	N/A	↑
		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	N/A	N/A	↑
		Overall Emergency Care Patient Satisfaction (%) - (QIP)	G	G	G	N/A	N/A	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

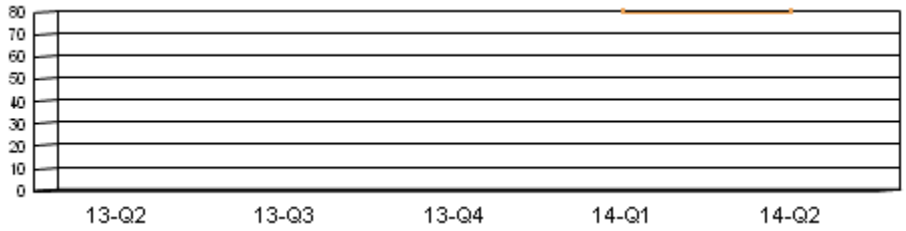
Kingston General Hospital

MS #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-Q2		
13-Q3		
13-Q4		
14-Q1		80
14-Q2		80

Interpretation - Patient And Business:

Patient Experience Advisors continue to be recruited to be involved as part of CI Teams, and in advance attend an education program specifically developed to support all advisors. The advisors are preferentially included in initiatives aligned to Gridlock and the patient safety initiatives reporting to the QPCC. To date 13 advisors have signed up for the education and expressed interest in involvement in team work, and 11 of the 13 have completed the training. The 11 advisors are presently populating 15 improvement teams associated with Gridlock, Patient Safety and standards for Patient and Family Centred Care. A few specific teams have 2 or 3 advisors. In addition, one advisor was part of the overall Gridlock VSM process prior to the education programming being made available.

Actions & Monitoring Underway to Improve Performance:

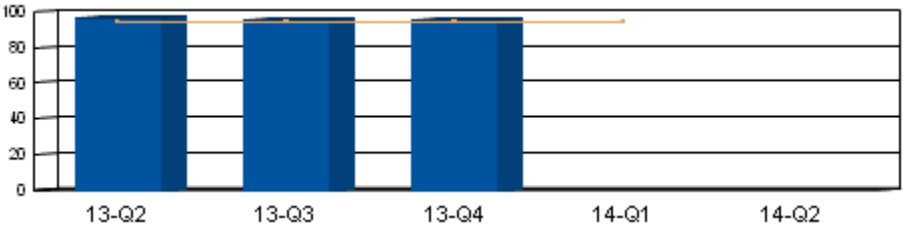
Continue to support education of advisors as it enables them to be equal partners in the CI/VSM processes; recruit advisors to be available to consider and become engaged in project work; support the process to catalogue their work and involvement; celebrate the involvement in the accomplishments of the teams through education events linked to patient safety week, board education, patient and family centred care month. It is noted that advisors are part of many improvement initiatives 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-Q2	96	94
13-Q3	95	94
13-Q4	95	94
14-Q1		94
14-Q2		

Interpretation - Patient And Business:

June NRCC Picker data file had an issue and NRCC staff has been working with KGH data file staff to re-submit the file. Apr-Jun quarter report is not due till middle of December. Surveys are still currently in-field.

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%

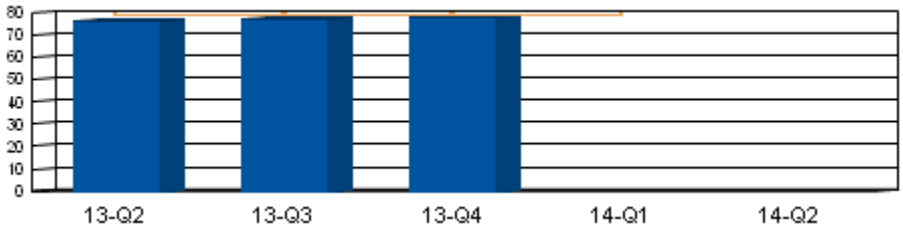
Kingston General Hospital

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

Interpretation - Patient And Business:

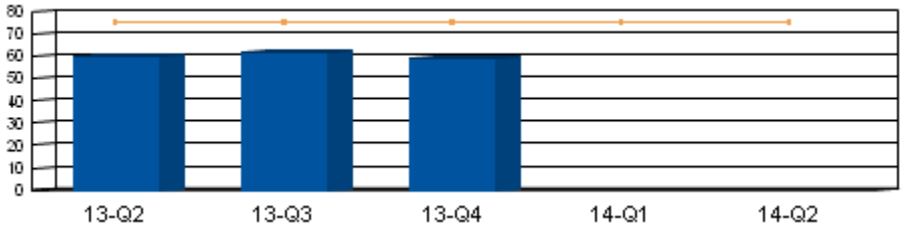
June NRC Picker data file had an issue and NRC staff has been working with KGH data file staff to re-submit the file. Apr-Jun quarter report is not expected until middle of December. Surveys are still currently in-field.

Definition: DATA: Pam Pero COMMENTS: Eleanor Rivoire

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

Interpretation - Patient And Business:

The overall patient satisfaction score from the Compass survey undertaken in July was 97%. The target for fiscal 2014 was 78% at the enthusiastic level (i.e. excellent/very good). The corresponding score for Q2 was 60%.

Actions & Monitoring Underway to Improve Performance:

Unfortunately a lower score was anticipated as the survey timeframe corresponded to the change in the menu selection software/process and the labour unrest caused by the introduction of standardized uniforms. However, the lower score cannot be attributable solely to these issues. Actions items have been developed to address areas where the survey scores are below target for this year.

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%

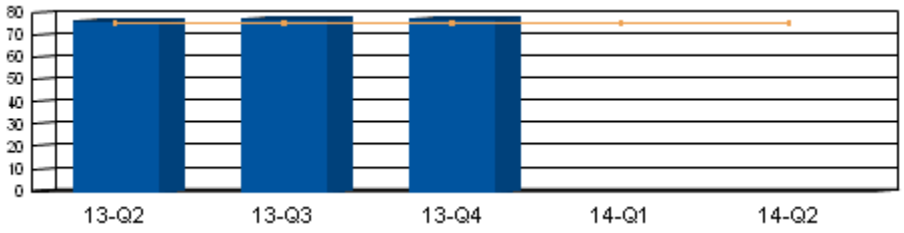
Kingston General Hospital

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

Interpretation - Patient And Business:

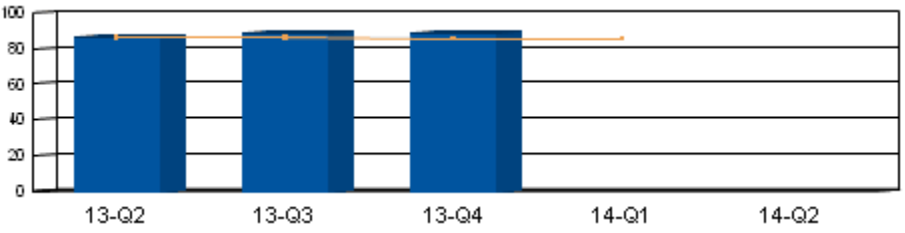
NRC Picker patient satisfaction data has not yet been made available to the hospital. Results will be updated as soon as data are received.

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

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



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

Interpretation - Patient And Business:

Data for Q2 is not yet available.

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

Definition: DATA: Astrid Strong COMMENTS: Julie Caffin

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

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?**
The actual indicator for this milestone is yellow with 1 of the 4 indicator initiatives showing progress and below target (Reduction in new hospital acquired infections). Three of the 4 indicators (falls, medication IV fluid events and lab specimen collection errors) have PDSA based initiatives underway and are yellow.

   Of the six red indicators, the most concerning is the Hand Hygiene compliance that has fallen Green to Red over the last 3 quarters. MRSA, VAP and VRE remain red, but have low incidence. CDI although red, continues in its third straight monthly decrease and a matching decrease Q1 to Q2. Antibiotic stewardship has supported the positive trending in the antibiotics dispensed per quarter.

   The best performance was seen in two indicators related to quality of care in the operation room environment. Surgical checklists should a 10% increase in the last quarter reaching 99.6% for all three phases. Surgical site infection prevention also reached 99% well above the target of 90%.

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)
Specimen Collection Errors: 3 areas of opportunity wrt blood collection (Phlebotomy team), glucometers (standard operating procedures) and urine sampling (container and process) – all in early phase of implementation.
Medication Fluid Events: two tactics underway – implementation of auto. Dispensing cabinets to address narcotic administration errors and CPOE for in patient Oncology.
Falls: Mobility falling star program underway; Patient and family engagement tool being designed.
Hand Hygiene:. A recent loss of a lead auditor has left a gap in process. Auditor training Is underway.
CAHO Antibiotic Stewardship: along with ties to the SE LHIN CSR

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?**
New processes are being put in place with the help of Decision Support to improve the quality of mortality reviews and compliance for timeliness of the review process. Critical Incident review of mortality with 5 days of surgery is also being implemented in Q3.

Kingston General Hospital

MS #02

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

14	13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
External Environmental Audits by Westech	Y	N/A	Y	Y	Y	↑
Hand Hygiene Compliance - (QIP)	Y	G	Y	Y	R	↓
Hospital Standardized Mortality Ratio (HSMR)	G	R	G	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	G	G	G	↑
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	G	N/A	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

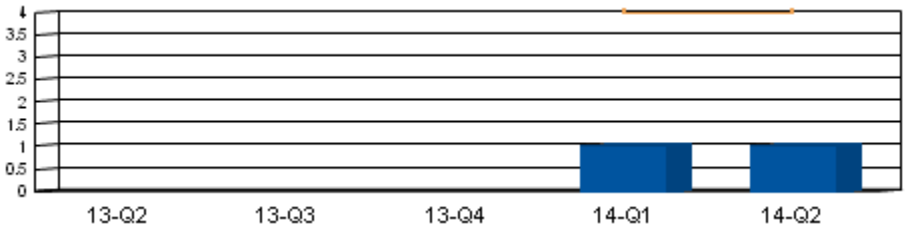
Kingston General Hospital

MS #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-Q2		
13-Q3		
13-Q4		
14-Q1	1	4
14-Q2	1	4

Interpretation - Patient And Business:

Teams to address Falls, Medication IV Fluid Events and Lab Specimen Collection Errors have initiated improvement cycles for this fiscal year. A reduction in new hospital acquired infections is supported with ongoing initiatives of hand hygiene, antibiotic stewardship and the Infection Prevention Control team.

Actions & Monitoring Underway to Improve Performance:

Teams have all begun implementing improvement priorities in Falls, Medication events and Lab errors. Q3/4 will be followed closely to observe impact. Reduction in new infections exceeds target in Q2.

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

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

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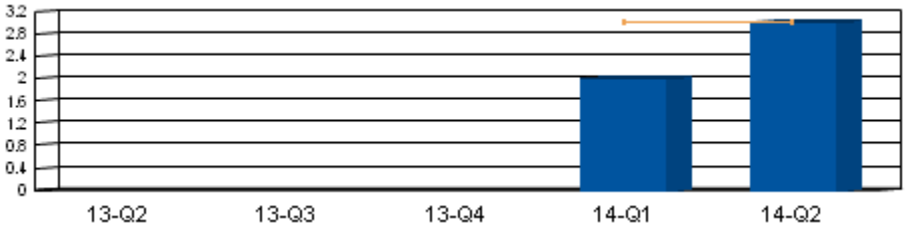
Indicator: Reduce the top 3 errors associated with specimen collection



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

Interpretation - Patient And Business:

Leaky urine update: 2 phase PDSA planned involving product container and process/ user to identify if any training or education is required. Phase 1 scheduled to start November 2013.Deviation from standard operating procedure (Glucose connectivity). Meetings involving Nursing Practice Council and with Clinical Educators have started. POCT to provide data.ID specimen mismatch/unlabeled; still in early phase of the implementation of a phlebotomy team (24/7 in ED). Focus on standard work, implementation plan for the other units underway.

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

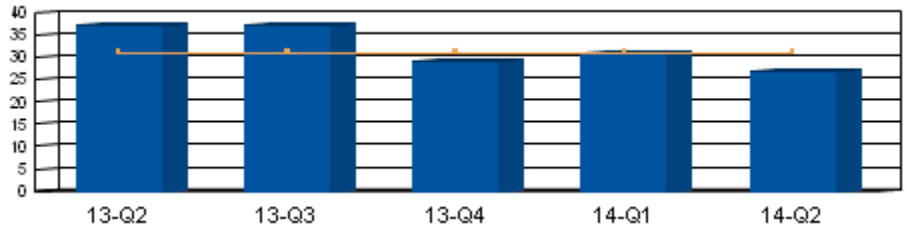
Kingston General Hospital

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-Q2	37	**31**
13-Q3	37	**31**
13-Q4	29	**31**
14-Q1	31	**31**
14-Q2	27	**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.

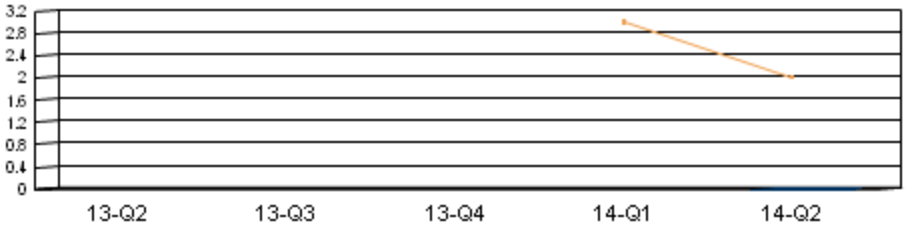
Business Perspective: The target reduction has been achieved principally due to a decrease in CDI infections over the last 17 months coupled with stable rates of MRSA and VRE bacteremias.

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-Q2		
13-Q3		
13-Q4		
14-Q1		**3**
14-Q2	0	**2**

Interpretation - Patient And Business:

Identified Tactics were presented to the Patient Safety Quality Committee and the Medication Safety Committee in September 2013.
The Medication Safety Committee suggested the following 2 tactics be selected for Fiscal 2013/14:
Tactic number 2 (Reduce the incidence of morphine and hydromorphone administration errors through the implementation of automated dispensing cabinets) and tactic number 6 (Support evidence-based, safe chemotherapy drug use through the implementation of computerized prescriber order entry for inpatient Oncology via OPIS 2005).

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

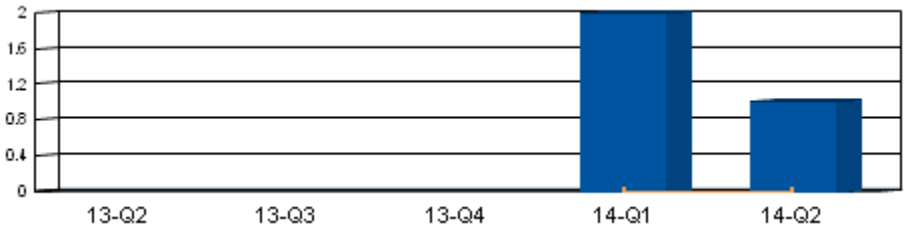
Kingston General Hospital

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-Q2		
13-Q3		
13-Q4		
14-Q1	2	**0**
14-Q2	1	**0**

Interpretation - Patient And Business:

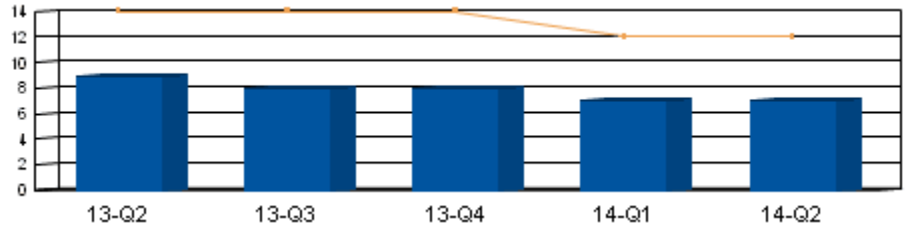
A Falls Tactic Team has been established and improvement cycles for Mobility Falling Star Program are in 'spread' phase. The team will be identifying other opportunities for improvement and presenting these to the Patient Safety Quality Committee. The team has collated and reviewed initial data and is designing a patient, family & staff engagement tool to expand on the quantitative data available with qualitative data.

Definition: DATA: Richard Jewitt COMMENTS: Richard Jewitt

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-Q2	9	**14**
13-Q3	8	**14**
13-Q4	8	**14**
14-Q1	7	**12**
14-Q2	7	**12**

Interpretation - Patient And Business:

Performance in Q2 remains stable at 7 out of 12 indicators (58%) being on track. Of note is the Surgical Safety Checklist indicator going from Red to Green achieving a 99% rating. Hand Hygiene continues to track in the wrong direction dipping to 86% down from a high of 95% in Q3 of last year. Timeliness of completion of mortality reviews continues to be an issue as well as readmissions rates and edischarge summary compliance.

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

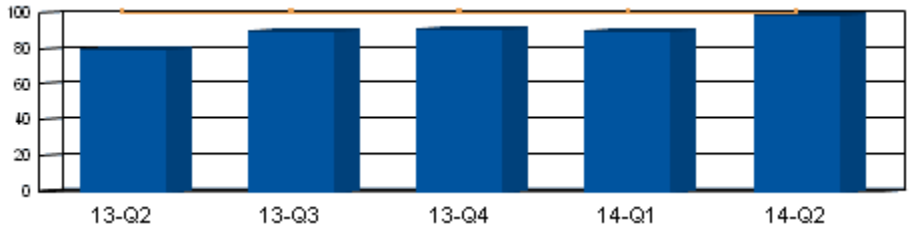
Kingston General Hospital

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-Q2	80	**100**
13-Q3	90	**100**
13-Q4	91	**100**
14-Q1	90	**100**
14-Q2	99	**100**

Interpretation - Patient And Business:

For Q2 this is the first time that this metric has hit the green target in 2 1/2 years.

Overall the compliance for all services to complete the 3 phases of the surgical safety checklist for all operative activity (urgent, elective) for this second quarter (2,155 cases) is the following: Briefing - 99.6%, Timeout- 99.4% and the final Debrief - 99.4%. Focus on urgent/emergent activity SSCL reporting continues in order to meet the overall average target of 100%.

Actions & Monitoring Underway to Improve Performance:

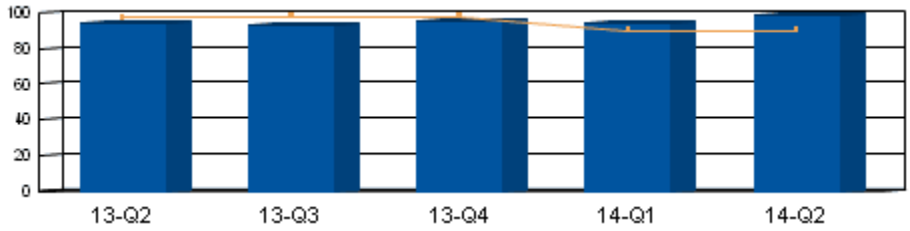
SPA management continues to support compliance with the electronic capture of the 3 phases.

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-Q2	94	**97**
13-Q3	93	**98**
13-Q4	95	**98**
14-Q1	94	**90**
14-Q2	99	**90**

Interpretation - Patient And Business:

Patient Perspective: Achieving the target for the appropriate timing of prophylactic antibiotic administration, for primary hip and knee replacements, reduces the risk of postoperative infections.

Business Perspective: Real time electronic documentation of the OR record was implemented last quarter and as a result our compliance has remained well above the target.

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

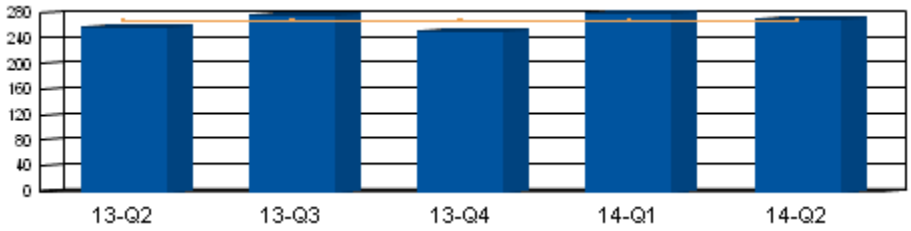
Kingston General Hospital

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



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

Interpretation - Patient And Business:

Reduced targeted antibiotic use has been maintained since Quarter 1 but not at QIP target. We have not seen jumps in non-targeted anibiotics to date suggesting some mitigation of increasing antibiotic use often seen during this quarter annually. At the same time this has happened at a time where staffing resources in ASP are still not optimal as resources were pulled as of May 1st from the broader organization to focus on the ICU antibiotic usage.

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%

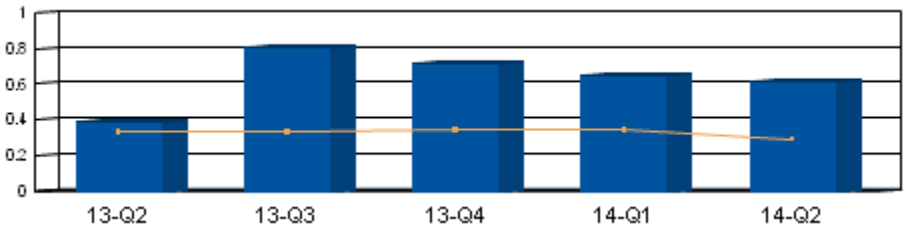
Kingston General Hospital

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: C-Difficile (Reported Monthly)



	Actual	Target
13-Q2	0.39	**0.33**
13-Q3	0.81	**0.33**
13-Q4	0.72	**0.34**
14-Q1	0.65	**0.34**
14-Q2	0.62	**0.29**

Interpretation - Patient And Business:

Patient Perspective: The last 5 quarters monthly values were: May - 9 cases; June - 8 cases; July - 7 cases (4 cases were identified on one unit within a 4 week period); August - 3 cases and September - 11 cases (4 cases were identified on one unit within a 4 week period).

Business Perspective: 16 months with no CDI outbreaks facility wide or unit specific.

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

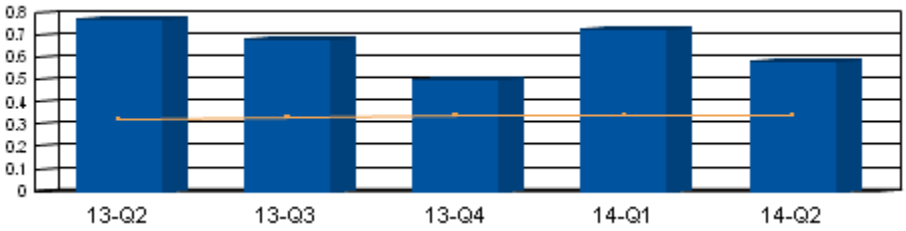
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: C-Difficile (Reported Quarterly)



	Actual	Target
13-Q2	0.77	**0.32**
13-Q3	0.68	**0.33**
13-Q4	0.50	**0.34**
14-Q1	0.73	**0.34**
14-Q2	0.58	**0.34**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.58 cases per 1000 patient days; a decrease from the first quarter of 2013- 2014. In July we had 7 cases of CDI. In August, we had 3 cases and in September there were 11 cases giving us a total of 21cases for the quarter; in comparison to quarter 1, where we had 27 cases.
Business Perspective: It is worth noting that we also had 20 additional cases of CDI admitted to KGH that were attributed to community or other facilities. We are now at 17 months without a CDI outbreak.

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

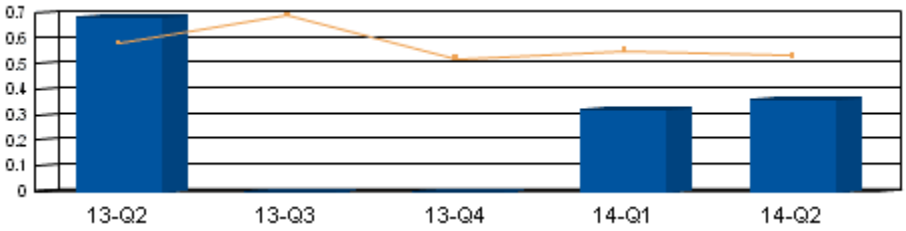
Kingston General Hospital

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-Q2	0.68	**0.58**
13-Q3	0.00	**0.69**
13-Q4	0.00	**0.52**
14-Q1	0.32	**0.55**
14-Q2	0.36	**0.53**

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.. This is a challenge given critical care is not the only user of CLs but needs to create what works best from an evidence informed perspective for insertion of CL in critical care

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

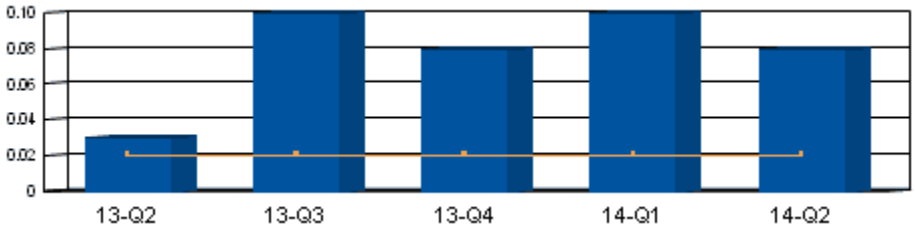
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: MRSA (Methicillin-resistant Staphylococcus Aureus)



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

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.08 per 1000 patient days which represents 3 cases. We had experienced one case each in July, August and September. Both the cases in July and August were with patients previously known to be colonized with MRSA and had previous infections. September's case was newly positive for MRSA.
Business Perspective: Based on our current patient days, the target as indicated represents less than 1 case per quarter.

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

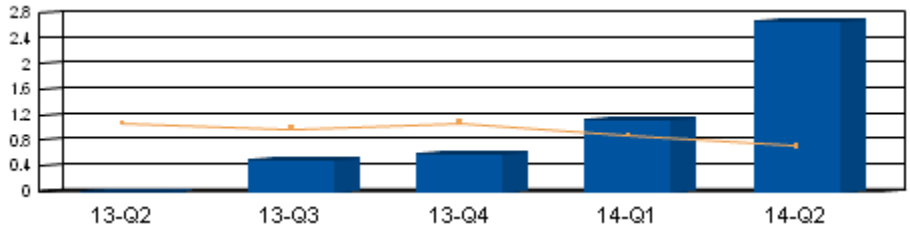
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Ventilator Associated Pneumonia



	Actual	Target
13-Q2	0.00	**1.1**
13-Q3	0.50	**1.0**
13-Q4	0.60	**1.1**
14-Q1	1.13	**0.9**
14-Q2	2.66	**0.7**

Interpretation - Patient And Business:

Rate above target but related to a decrease in ventilator days (very quiet Q2) reducing the denominator and increasing the impact of the four (4) cases that were documented to have VAP this quarter.

Actions & Monitoring Underway to Improve Performance:

If ventilator days would not have decrease, the rate would have been slightly above current expected norm. Additionally efforts in place to improve identification of VAP cases. Continue to monitor closely to determine if trend has 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

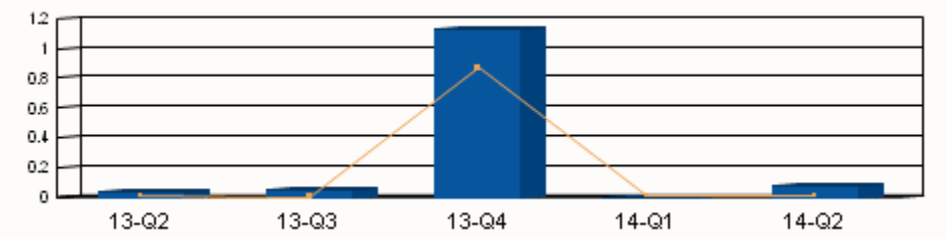
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
13-Q2	0.03	**0.01**
13-Q3	0.05	**0.00**
13-Q4	1.13	**0.87**
14-Q1	0.00	**0.01**
14-Q2	0.08	**0.01**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0.08 per 1000 patient days which represents 3 cases. We experienced two cases in August and one case in September.

Business Perspective: Based on our current patient days, the target as indicated represents less than 1 case per quarter.

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

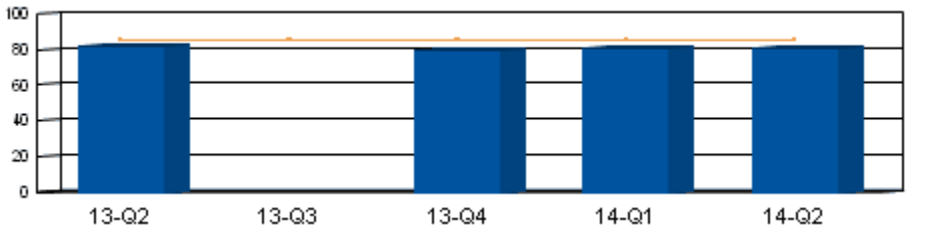
Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. If a person has an infection caused by VRE, such as a blood infection, 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-Q2	82	**85**
13-Q3		**85**
13-Q4	79	**85**
14-Q1	81	**85**
14-Q2	81	**85**

Interpretation - Patient And Business:

81% represents an improvement over the past audit as we continue to work with our teams to reach our target of 85%.

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%

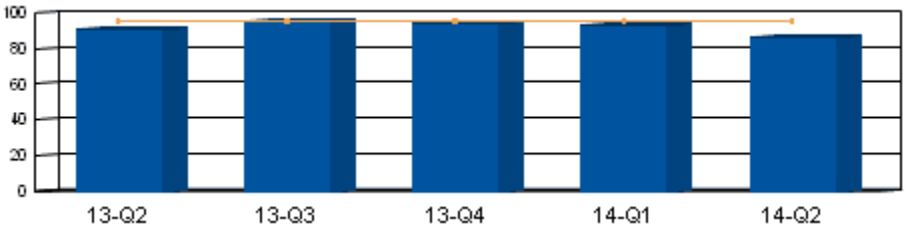
Kingston General Hospital

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: Hand Hygiene Compliance - (QIP)



	Actual	Target
13-Q2	91.0	**95**
13-Q3	95.0	**95**
13-Q4	94.0	**95**
14-Q1	93.0	**95**
14-Q2	86.3	**95**

Interpretation - Patient And Business:

Patient Perspective: During July, August and September IPAC trained 13 new hygiene auditors with recent requests for an additional 28 new auditors to be trained. IPAC recognizes that it does take new auditors time to become skilled with the device and how to identify and capture all hand hygiene opportunities. IPAC encourages auditors to contact us for additional support or instruction during their learning process.
Business Perspective: For this quarter we captured 1325 observations of Moment 1(before initial patient/patient environment contact).

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%

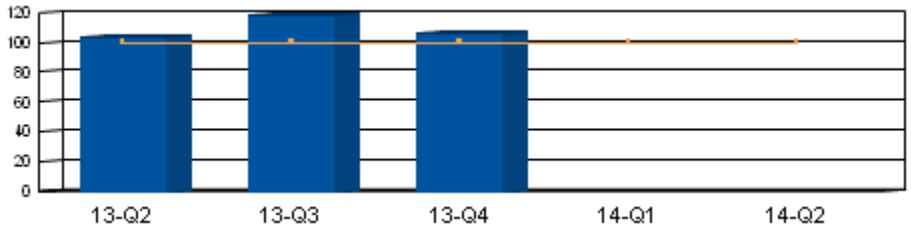
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Hospital Standardized Mortality Ratio (HSMR)



	Actual	Target
13-Q2	103	**100**
13-Q3	119	**100**
13-Q4	106	**100**
14-Q1		**100**
14-Q2		**100**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

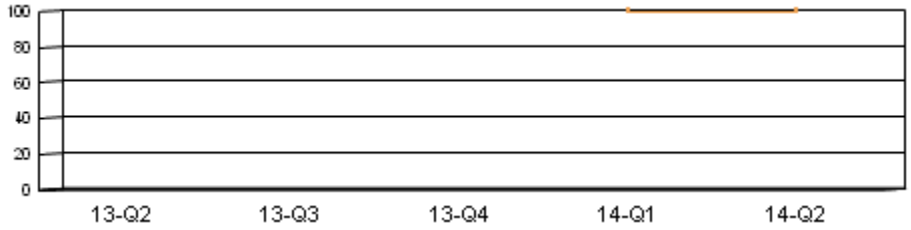
The most recent data available data from CIHI is Q4 of fiscal 12/13. The HSMR for Q4 was deemed not significant by the Canadian Institute for Health Information (CIHI) and the HSMR for the complete fiscal year 12/13 was also deemed not significant. The Canadian Institute for Health Information (CIHI) provides the HSMR calculations to all hospitals in Ontario. Quarterly morality reviews are on-going by the clinical departments. Any concerns or trends are reported to the MAC's Joint Quality and Utilization Committee. Of note is a continued drop on the 5 year annual mortality rate.

Definition: 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-Q2		
13-Q3		
13-Q4		
14-Q1		**100**
14-Q2		**100**

Actions & Monitoring Underway to Improve Performance:

This new indicator now has processed identified to supply lists of deaths meeting the criteria of mortality within 5 days of surgery. Implementation of a mortality review process will be implemented through Q3 and Q4

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%

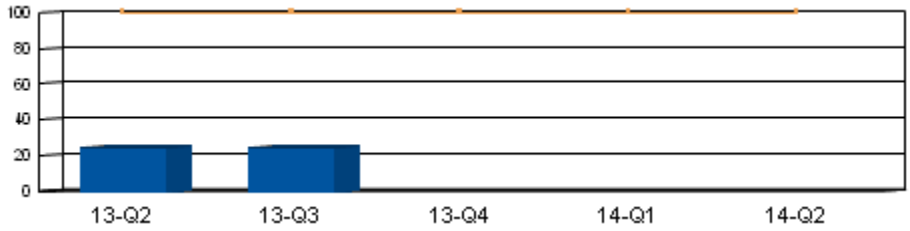
Kingston General Hospital

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

Actions & Monitoring Underway to Improve Performance:

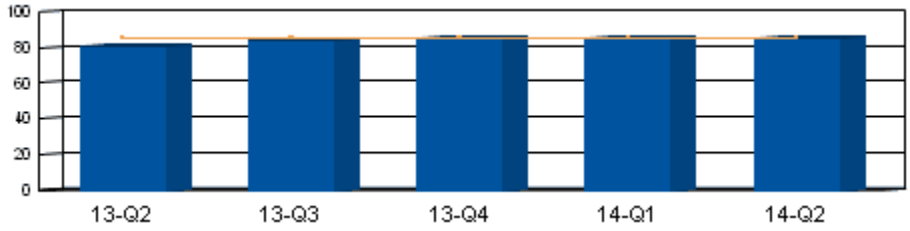
Mortality reviews, although completed, are not done in the time frame of a quarterly review period. Over 2 years of review, there have been no recommendations coming forward. The process has been redesigned to have the Departments to review mortality from the most recent quarter rather than historically identified through HSMR (up to 12-18 months later). A focus on mortality related to sepsis will align to MoH initiatives.

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-Q2	81	**85**
13-Q3	84	**85**
13-Q4	85	**85**
14-Q1	85	**85**
14-Q2	85	**85**

Interpretation - Patient And Business:

The Q2 results are the most recent results which are received through the NRC + Picker Patient Satisfaction Survey which is conducted on discharge. This current result demonstrates improvement and has meant our target of 85%. Our leadership will continue to work with our staff.

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%

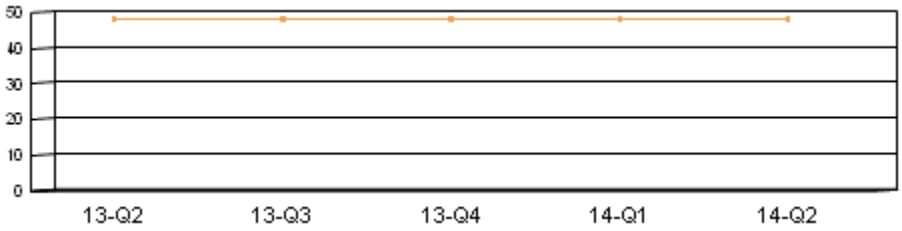
Kingston General Hospital

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

Interpretation - Patient And Business:

It is of note that this survey was last administered in Q4 of fiscal 11/12. At that time the result was 28%.

Actions & Monitoring Underway to Improve Performance:

The survey has been completed but data analysis has not. Q3 should see result inputted into the performance charts.

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%

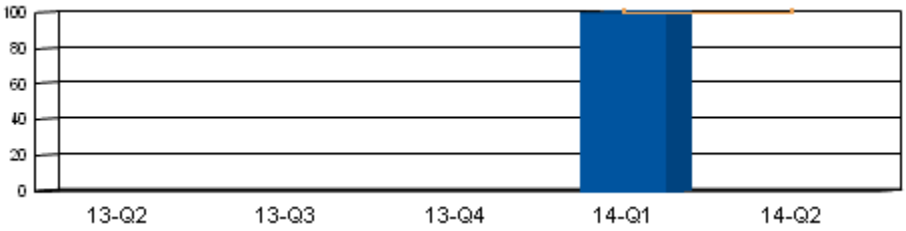
Kingston General Hospital

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 Recommendations Considered and Acted Upon as per Critical Incident Investigations



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

Actions & Monitoring Underway to Improve Performance:

With the recent vacancy of the Director of Patient Safety, Quality and Risk, the data analysis has not been completed. All critical incidents do generate however, recommendations and followed to completion via patient experience specialist input.

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?** In Q2 there was 1 Gridlock in August. This is an improvement relative to Q1 which had 5 Gridlocks, and relative to Q2 2013 which had 2. The duration of the Gridlock in Q1, however, was significant in duration (4 days). The work on the corporate VSM process which was launched in May continues. By end of Q2, the 90-120 day PDSA cycles on 4 of the 5 top priority processes had moved into the stage of planning and implementation of redesigned processes. One process, involving the consultation process for decision to admit in the ED, is being revisited, and will continue with another PDSA in Q3. As well, three new priorities have been selected to begin the next 90-120 day PDSA cycles. Project teams are typically interprofessional in make up and include at least one patient experience advisor.

   Of the 31 supporting indicators aligned to patient flow, 5 do not have Q2 data available. Of the remaining 26, 50% (n=13) are green; 12% (n=3) are yellow and 38% (n=10) are red. There is noted success with 17 of the 18 clinical services exceeding the expected length of stay. Neurology, the service yet to meet this target, is working closely with the region with focus on support for Stroke patients. The indicators not meeting the thresholds are linked to Alternate Level of Stay; surgical wait times

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** With each Gridlock, there continues to be 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. Specific tactics (such as introduction of patient navigator positions in Medicine; RAZ in ED; review of corporate bed map; support for Health Links) support measures aligned to patient flow; Length of Stay; readmissions.

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 oversees Gridlock & meets biweekly with updates on the PDSA improvement cycles. In Q2, the VSM was completed, and a total of 20 CI opportunities were identified for process improvements affecting flow of patients admitted in the ED through to time of discharge. 5 were included in the first round of PDSA's, 3 new ones have been launched and capacity will be reviewed for next priorities in January 2014. The Wait List Committee reviews metrics aligned to surgical, cancer, cardiac and diagnostic imaging wait times on a monthly basis, and ensures engagement of clinical and program leaders; support for scheduling and wait list processes, and focus on steps that need to be taken to remove barriers to moving toward targets. The Nov/13 opening of convalescent care beds in Napanee is expected to alleviate some pressure with ALC rates. There is also to be focused discussion by SECHEF on repatriation and gridlock which will support a more regional focus on these challenges.

Kingston General Hospital

MS #03

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	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	Y	Y	
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	Y	Y	Y	R	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	Y	Y	Y	R	R	↓
		General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	Y	Y	R	R	G	↑
		All Paediatric Surgery - 90th Percentile Wait Time (Days)	Y	G	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)	Y	Y	Y	R	R	↓
		Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)	G	G	G	G	G	↑

33	13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	R	R	
Overall - Acute Average Length of Stay Days (Based on HSAA)	G	Y	G	G	G	
Overall - Acute Average Length of Stay vs ELOS Variance in Days	Y	G	Y	G	G	
Percent of Clinical Services Meeting or Exceeding ELOS Target	R	R	R	Y	G	
Number of Inpatient by Program Floor Assignment Patient Days Within Budget	N/A	N/A	N/A	Y	G	
Reduce the Number of Avoidable Admsisions	N/A	N/A	N/A	R	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	R	R	R	R	Y	
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs	Y	Y	Y	Y	G	
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	R	R	R	Y	Y	
Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	Y	G	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	G	Y	

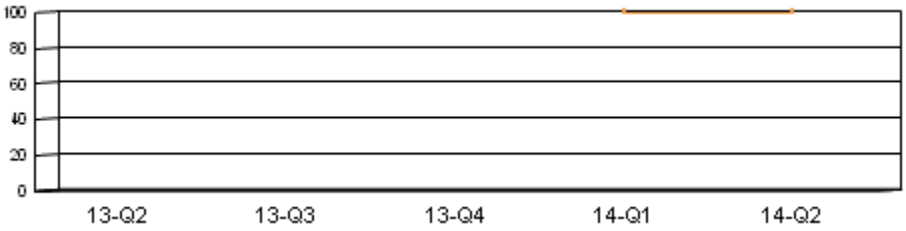
Kingston General Hospital

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

Interpretation - Patient And Business:

In Q2 there was 1 Gridlock in August. This is less relative to Q1 which had 5 Gridlocks, and relative to Q2 2013 which had 2. The duration of the Gridlock in Q1 however was significant in duration (4 days). The work on the corporate VSM process which was launched in May continues. By end of Q2, the 90-120 day PDSA cycles on 4 of the 5 top priority processes had moved to stage of planning the implementation of roll-out to all areas. One process, involving consultation process for decision to admit in the ED, is being revisited, and will continue with another PDSA. As well, three new priorities have been selected to begin the next 90-120 day PDSA cycles. Project teams are typically interprofessional in make up and include at least one patient experience advisor.

With each Gridlock, there continues to be 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. In Q2, the full review of the entire VSM was completed. There are a total of 20 CI opportunities identified by the Gridlock VSM group for the patient flow for patients admitted in the ED through to time of discharge. 5 were included in the first round of PDSA's, 3 new ones have been added and capacity will be reviewed for next priorities in January 2014.

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 responsibility 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%

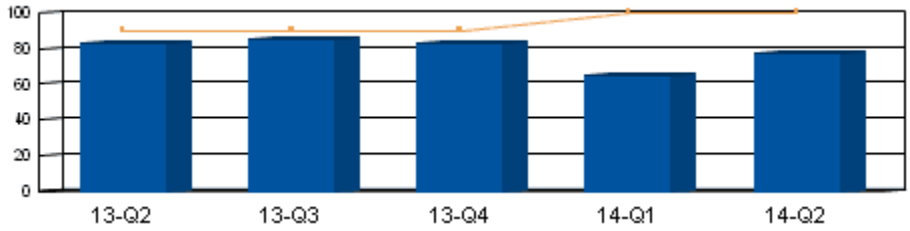
Kingston General Hospital

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-Q2	83	**90**
13-Q3	85	**90**
13-Q4	83	**90**
14-Q1	65	**100**
14-Q2	77	**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:

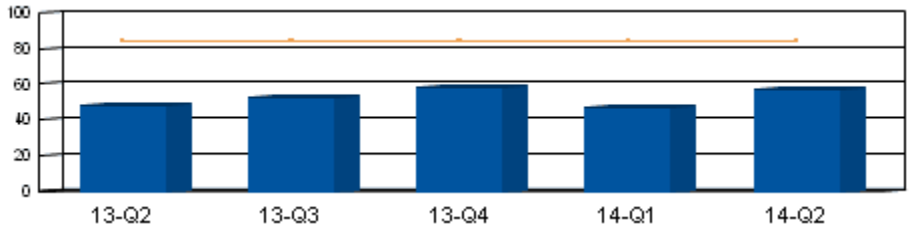
A has been a modest increase in the number of services meeting the 90th percentile wait time target has occurred in Q2. 12 of 52 clinical areas have a status of Red with respect to meeting their wait time targets (1 general surgery; 3 gynecology; 1 neurosurgery, 3 orthopedic; 2 Plastic surgery; 1 urology, and 1 DI (MRI). The Wait Time Committee continues to review the current change and focus on sustainability of initiatives that lead to the improvements in wait times.

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-Q2	48	**84**
13-Q3	52	**84**
13-Q4	58	**84**
14-Q1	47	**84**
14-Q2	57	**84**

Interpretation - Patient And Business:

For Q2 this indicator continues to achieve its green performance target. There were 223 cancer procedures completed in this quarter with a 90% percentile wait time of 58 days in July decreasing to 54 days in September this continues to positively exceed the 84 day target.

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 operating room time has been scheduled to support ENT head and neck surgical volumes.

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

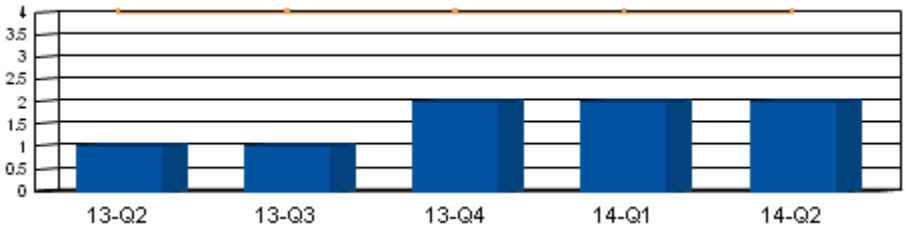
Kingston General Hospital

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

Interpretation - Patient And Business:

At the end of Q2 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 (Q2 F14 performance is 100%). The other three indicators, Radiation Referral to consult, Systemic referral to consult, and Systemic Consul to Treatment are consistently not being met (63%, 66%, and 61% respectively). Consultation interval performance impacted by summer vacation (August is peak vacation time) and vacancies in medical staff (with a new medical oncologist starting in September and a radiation oncologist returning from maternity leave in September). Performance should improve on October with Division Heads monitoring access. Systemic treatment access continues to be impacted by patient choice, other treatment (i.e. surgery), and inpatient chemotherapy as a first line of treatment – all of which are not included in the Cancer Care Ontario indicator. Project initiated with gyne oncology to improve data reporting. Monthly audits continue to ensure there are no avoidable delays in treatment.

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 85% 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)

Definition: DATA: Decision Support - Cancer (K. Balchin) 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

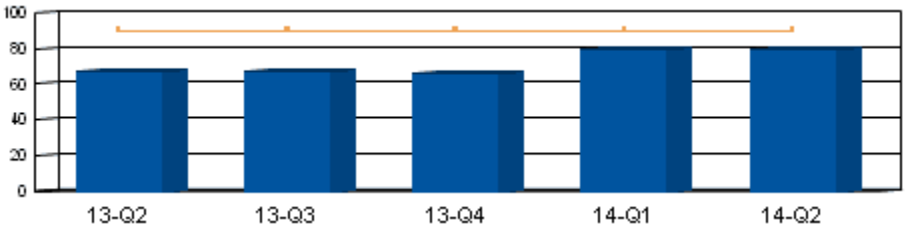
Kingston General Hospital

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-Q2	67	**90**
13-Q3	67	**90**
13-Q4	66	**90**
14-Q1	79	**90**
14-Q2	79	**90**

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 Q2 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 Q2, KGH did not meet the Cancer Care Ontario Cancer Surgery contracted target; however, the gains seen in Q1 have been maintained. CCO target in this indicator is 90% of cases meeting wait time target and only three out of 14 LHINS are achieving 90% or better (Central, Central East and Central West). The provincial average at this time is 84% in all priority categories. Overall across the province, Q2 has been the poorest performance quarter of the year for every fiscal year since 07/08.

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.

Quality assurance of priority assignments also continues. For the first time in recent history, KGH is meeting provincial data quality standards in the priority 3 and 4 categories, meaning that our surgeons are coding cases more accurately. Efforts to ensure accurate priority coding are a major contributing factor to our overall performance since the start of this fiscal year.

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: Shankar Chowdhury 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%

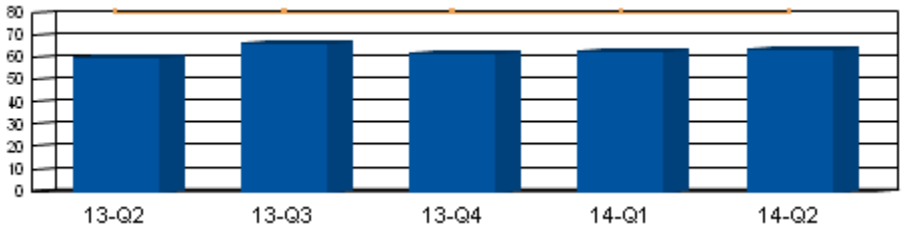
Kingston General Hospital

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-Q2	59.6	**80**
13-Q3	66.0	**80**
13-Q4	62.0	**80**
14-Q1	63.0	**80**
14-Q2	64.0	**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.
In Q2 F14, only 63% of all patients referred to KGH are seen by a radiation oncologist within 14 days. Access performance related primarily to summer vacation schedules (August is peak vacation schedule) and a vacancy within the radiation oncology division due to a maternity leave (returning in September). New report developed to flag cases that are scheduled to breech the 14 day target (to be implemented) with Division Head monitoring performance.

Definition: DATA: Katelyn Balchin 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%

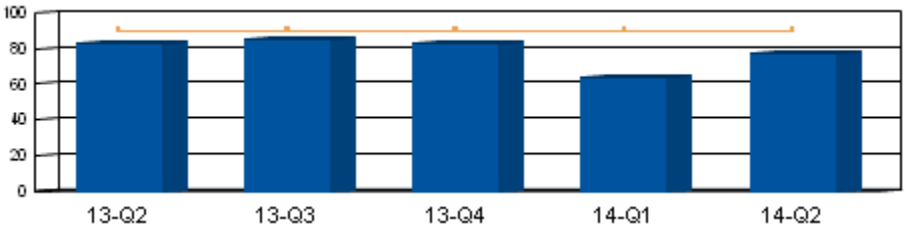
Kingston General Hospital

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



	Actual	Target
13-Q2	83	**90**
13-Q3	85	**90**
13-Q4	83	**90**
14-Q1	64	**90**
14-Q2	77	**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 improvement in services meeting the 90th percentile wait time target has occurred in the second quarter. There are 36 of 47 wait time services meeting the target (need improvement-1general surgery; 3 gynecology; 3 orthopedic; 2 Plastic surgery; 1 ped urology). The Wait Time Initiative Committee will review the current change and focus on sustainability of initiatives that lead to the improvements for Q3 and Q4.

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%

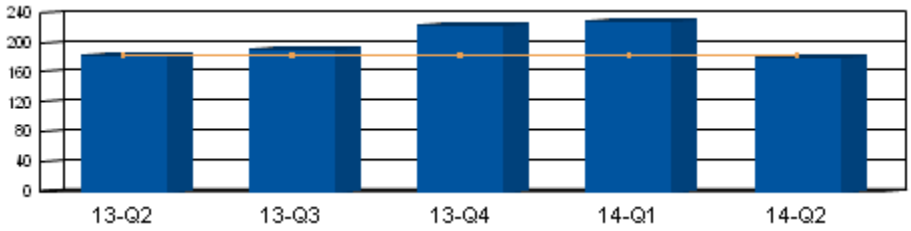
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q2	183	**182**
13-Q3	192	**182**
13-Q4	224	**182**
14-Q1	229	**182**
14-Q2	181	**182**

Interpretation - Patient And Business:

In this quarter there were 163 completed cases with 90% percentile wait times of 153 days in July increasing to 228 days in September. There were 6 completed cases during July and August this quarter that were on the wait list for 195, 213, 267,311,487, and 546 days which will influence the median and 90% percentile wait times. There were 15 cases cancelled in this quarter for the following reasons; case substitution (4), no bed (4), change in medical condition post PSS (2), emergency case substitution (1), patient no show (1), patient refusal (1) unexpected surgical complication previous case (2)

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to support physician office administration in monitoring and managing the wait lists appropriately. The wait times are tabled on the SPA program council for review along with the Wait Times/Quality Based Procedure Committee.

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

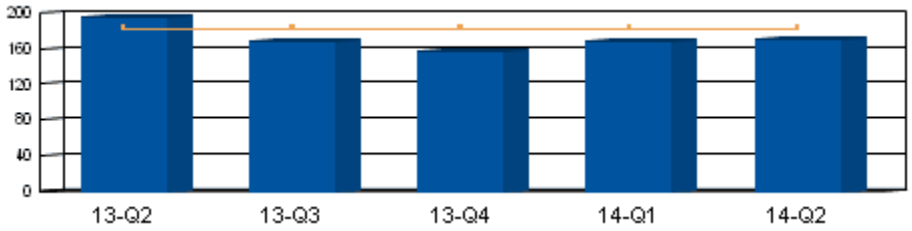
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q2	195	**182**
13-Q3	167	**182**
13-Q4	157	**182**
14-Q1	167	**182**
14-Q2	170	**182**

Interpretation - Patient And Business:

For Q2 this indicator continues to meet the green target corridor even though OR activity access was reduced across all services in July and August due to human resource vacancies. Pediatric surgical service activity for this quarter is the following:

General Surgery (13 completed cases):
All completed cases were within acceptable wait time targets. There are currently 5 cases on the wait list within target times.

Orthopedics (25 completed cases):
For this service the 90% was 183 days in July decreasing to 177 days in September. One completed case had a wait time of 618 days. There are currently 24 pediatric ortho cases on the wait list with 7 cases over target between 206 and 1288 days.

Urology (8 completed cases):
The 90% percentile for pediatric urology was 183 days in July decreasing to 177 days in September. There are 14 cases currently waiting on the list with 3 cases over target between 183 and 187 days.

ENT (25 completed cases):
For this service the 90% percentile for July was 317 days trending positively to 109 days in September. There are currently 23 non cancer cases on the waitlist with 7 of these cases already over the 182 day target.

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to support physician office administration in monitoring and managing the wait lists appropriately. The wait times are tabled on the SPA program council for review along with the Wait Times/Quality Based Procedure Committee.

The department has been unsuccessful to date in recruiting a replacement for the 0.5 FTE pediatric surgeon position.

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

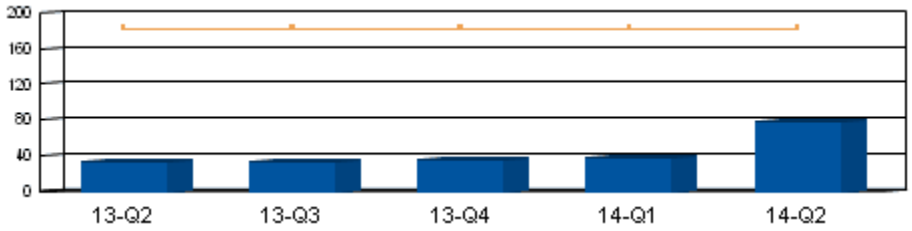
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q2	33	**182**
13-Q3	33	**182**
13-Q4	35	**182**
14-Q1	37	**182**
14-Q2	79	**182**

Interpretation - Patient And Business:

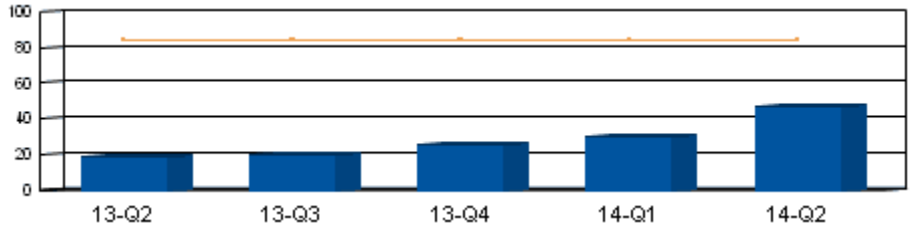
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: DATA: Decision Support COMMENTS: 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

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



	Actual	Target
13-Q2	19	**84**
13-Q3	20	**84**
13-Q4	26	**84**
14-Q1	30	**84**
14-Q2	47	**84**

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: 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

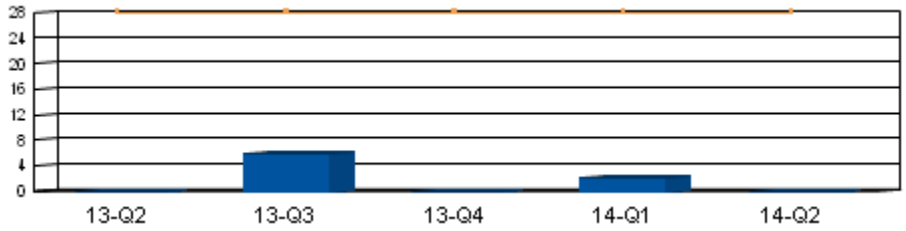
Kingston General Hospital

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 Angioplasty - 90th Percentile Wait Time (Days)



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

Interpretation - Patient And Business:

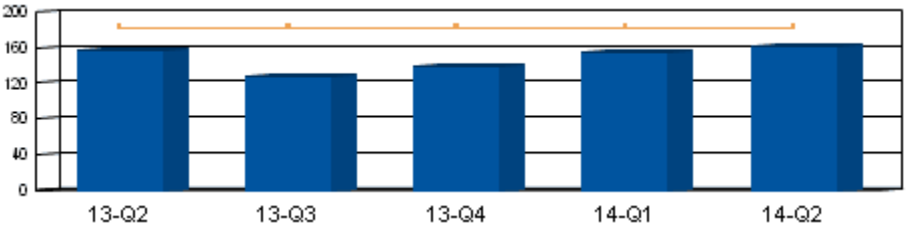
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: DATA: Decision Support COMMENTS: 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

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



	Actual	Target
13-Q2	156	**182**
13-Q3	127	**182**
13-Q4	139	**182**
14-Q1	154	**182**
14-Q2	161	**182**

Interpretation - Patient And Business:

For Q2 this indicator is still well below target although a slight increase in wait time can be related to a decrease of operating room activity during the months of July and August due to human resource vacancies. There were 74 completed cases with a 90% percentile of 166 days in July increasing to 195 days in September. In this time period there were cancelled surgery cases due to incorrect booking (1), no available bed (2) and unexpected surgical complications with the previous cases (1).
There are currently 192 patients on the wait list with 80 of them having already waited more than the 182 day target.

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to support physician office administration in monitoring and managing the wait lists appropriately. The wait times are tabled on the SPA program council for review along with the Wait Times/Quality Based Procedure 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

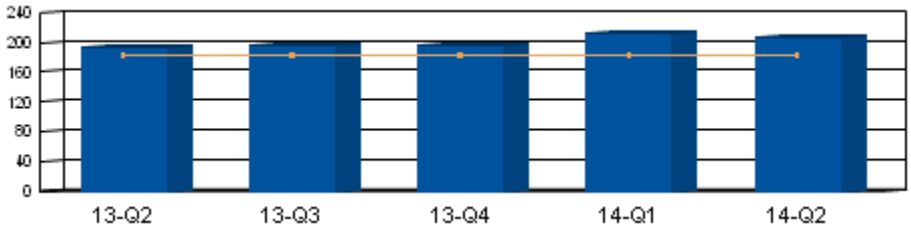
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q2	193	**182**
13-Q3	197	**182**
13-Q4	196	**182**
14-Q1	212	**182**
14-Q2	206	**182**

Interpretation - Patient And Business:

For Q2 there were 131 completed cases with a 90% percentile wait time of 119 days in July increasing to 211 days in September. In this time period there were 14 cancelled surgery cases of which 6 cases were patient related (did not show, non-compliant, unavailable.) 4 cases-unexpected previous case surgical complications/ emergency case substitutions, and 4 remaining cases for incorrectly booked, equipment broken, insufficient time, surgeon's decision. Also influencing these wait times was the reduced OR surgical activity in July and August due to human resource vacancies.

There are currently 210 patients on the wait list with 92 already over the 182 day target. SPA program has worked physician office secretaries to manage these wait lists.

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to support physician office administration in monitoring and managing the wait lists appropriately. The wait times are tabled on the SPA program council for review along with the Wait Times/Quality Based Procedure Committee. The SPA program has been offering a Perioperative Hybrid operating room course (10 candidates) in partnership with Algonquin College which will assist in addressing the staffing vacancies in future.

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

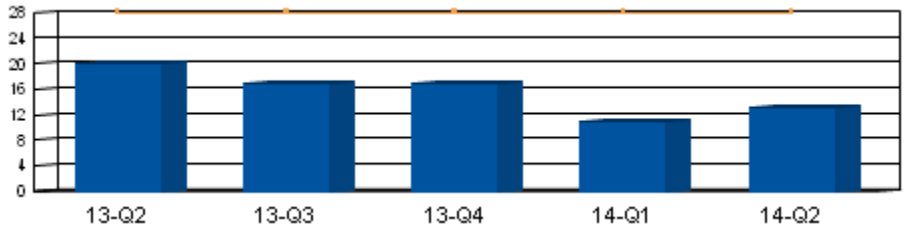
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



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

Interpretation - Patient And Business:

KGH serves mainly ER, inpatients and timed studies. Therefore the majority of our patients fall within the P1 to P3 category. It is expected that our wait time should be 15 days or less. Successfully achieved.

Actions & Monitoring Underway to Improve Performance:

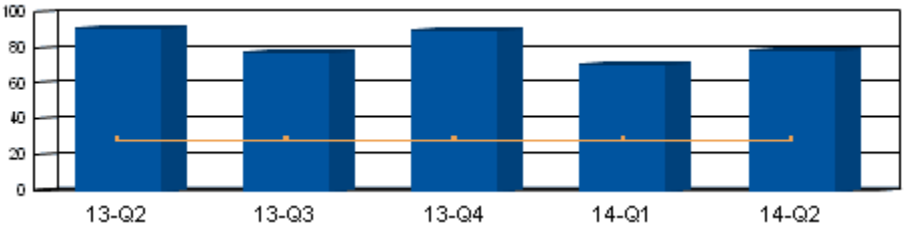
Continue to achieve wait time of 15 days or less.

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

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



	Actual	Target
13-Q2	91	**28**
13-Q3	77	**28**
13-Q4	90	**28**
14-Q1	70	**28**
14-Q2	78	**28**

Interpretation - Patient And Business:

The demand on the magnet is far larger than a single magnet can accommodate. The need to serve emergent and inpatient cases first due to their urgency pushes the wait times for P3 and P4 cases far beyond the preferred date.

This is frustrating for patients and care providers as diagnosis and treatment is often delayed while waiting for the MRI. Constant prioritization and re-prioritization of cases occurs. As does booking and rebooking to accommodate more urgent cases.

Significantly high sick time in MRI has resulted in decreased operational hours. 2 new PT staff has been hired in order to maintain wait time hours.

Actions & Monitoring Underway to Improve Performance:

Submission for approval of second tertiary care magnet is now a MOH level awaiting approval.

Staffing has been increased. New technologists to start in November and December.

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

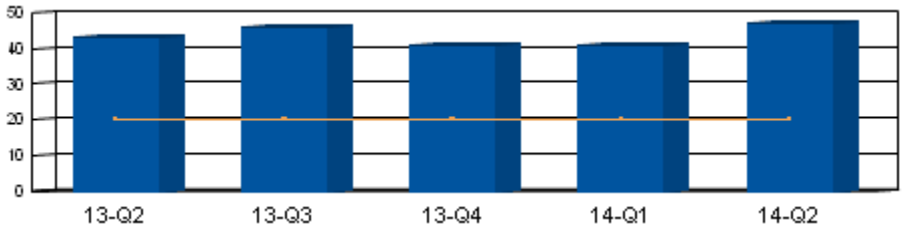
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Average # ALC Patients per Day



	Actual	Target
13-Q2	43	**20**
13-Q3	46	**20**
13-Q4	41	**20**
14-Q1	41	**20**
14-Q2	47	**20**

Interpretation - Patient And Business:

The average number of ALC patient's remains well above the target. ALC patients awaiting admission to a long term care home account for the majority of the total number. Reasons for high LTC patients include the number of choices for LTC homes that patients make the location of the choices, and the accommodation type. Reduced choices, requests for popular locations and basic accommodation requests result in very long wait times.

Reasons for the high numbers of ALC patients include complexity of medical issues preventing admission to Home First, reduced access to LTC beds due to crisis placements from the community, lost opportunity for access to LTCHs based on a second priority 1A access for L&A.

ALC-Rehab designations increased in this quarter as a result of process review/revision. The process review improved accuracy of the ALC list, but in doing so increased the numbers of patients fitting the designation.

Actions & Monitoring Underway to Improve Performance:

Actions in progress include: ongoing discussions with patients and families with regards to choices for LTC homes, access to convalescent beds in November 2013, and rollout of the RM&R process for complex continuing care and rehab beds.

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

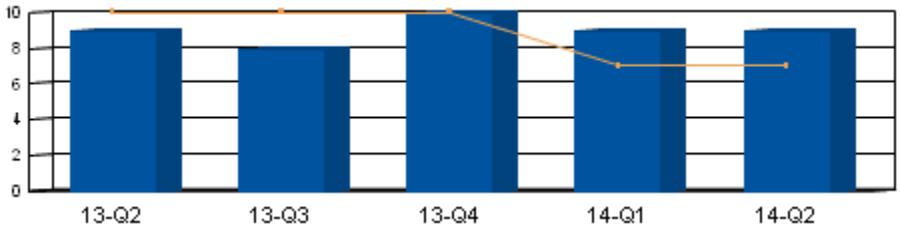
Kingston General Hospital

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

Interpretation - Patient And Business:

The percent ALC days holding at 9% with the average number of ALC patients per day climbing this past quarter reflects the ALC activity in the rehab destination.

Actions & Monitoring Underway to Improve Performance:

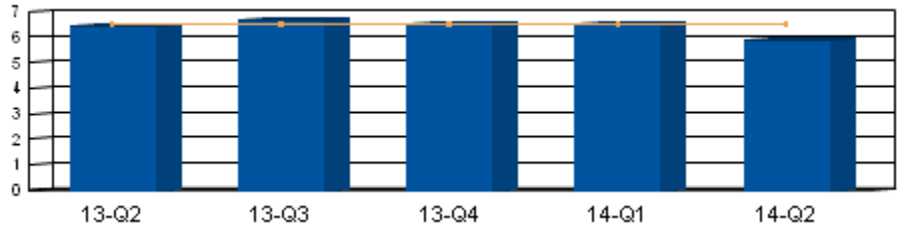
Continue to pursue options to enable a reduced length of stay for the ALC population. New convalescent beds and restorative rehab beds may promote patient flow i.e. patients who previously have been designated long term care, may have the opportunity for these new destinations.

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-Q2	6	**6.5**
13-Q3	7	**6.5**
13-Q4	7	**6.5**
14-Q1	7	**6.5**
14-Q2	6	**6.5**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The average length of stay for Q2 at 5.9 days is 0.6 days below the target of 6.5 days, the best performance in the history of this indicator. It is also worth noting that our average length of stay compared to expected length of stay is 1.1 days below our expected. There continues to be tremendous efforts placed on maintaining this level of performance across all services.

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

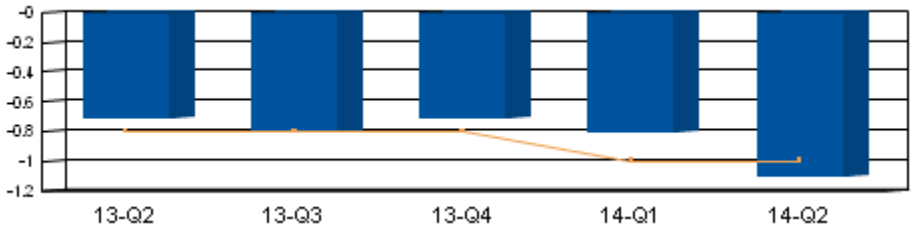
Kingston General Hospital

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-Q2	-0.7	**-1.0**
13-Q3	-0.8	**-1.0**
13-Q4	-0.7	**-1.0**
14-Q1	-0.8	**-1.0**
14-Q2	-1.1	**-1.0**

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q2. The -1.1 day variance for Q2 (fiscal 13/14) indicates that our overall actual length of stay remains below (or better) than our expected length of by 1.1 of a day, exceeding our target of -1.0 days. It is important to note that this is calculated on an overall basis. There remains opportunity in 1 of 18 services to achieve expected length of stay. The service of 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

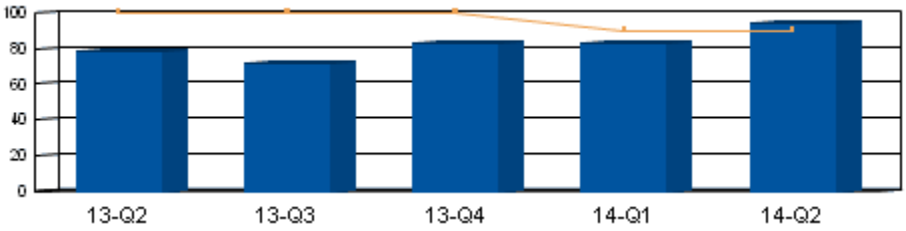
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Percent of Clinical Services Meeting or Exceeding ELOS Target



	Actual	Target
13-Q2	78	**100**
13-Q3	72	**100**
13-Q4	83	**100**
14-Q1	83	**90**
14-Q2	94	**90**

Interpretation - Patient And Business:

As of Q2 (fiscal 13/14), 94 percent of services (17 of 18) are achieving (or outperforming) their expected length of stay. It is of note that this green status is the best performance of this indicator over the last 3 years. The only service that is currently not at its expected length of stay is Neurology. It is a well understood challenge and one that the medicine program is focusing improvement cycles on - process and access to rehab for patients who have had a stroke. The aim would be to resolve this by the end of the year.

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: 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, 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%

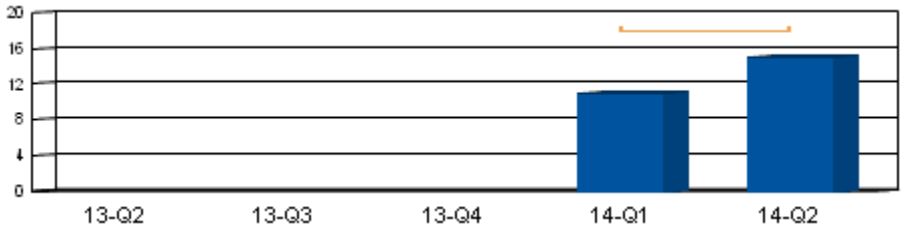
Kingston General Hospital

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 Inpatient by Program Floor Assignment Patient Days Within Budget



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

Interpretation - Patient And Business:

Clinical leaders oversee the occupancy of units, and support patient flow to extent possible - in some instances with overcapacity beds with a program, and in others with off servicing patients to units outside of the program. Medicine is typically the program that experiences greatest challenge with clinical surge. Work that is also aligned to the Gridlock VSM continues to coordinate efforts of those in ED, Admitting and clinical programs to optimize use of all beds (i.e. keep medicine short stay unit at 100% occupancy).

All efforts with achieving ELOS also contribute to best use of bed resources. All but one service (Neurology) are exceeding ELOS.

Actions & Monitoring Underway to Improve Performance:

Continue oversight with clinical programs and Patient Flow Task Force, with alignment of efforts to Gridlock VSM. Review of the Corporate Bed Map has been launched to determine what if any changes in allocation of beds to programs should be made to make best use of bed resources (shift from programs with lower occupancy). Work to unfold in Q3 with potential of bed map redesign in Q4.

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

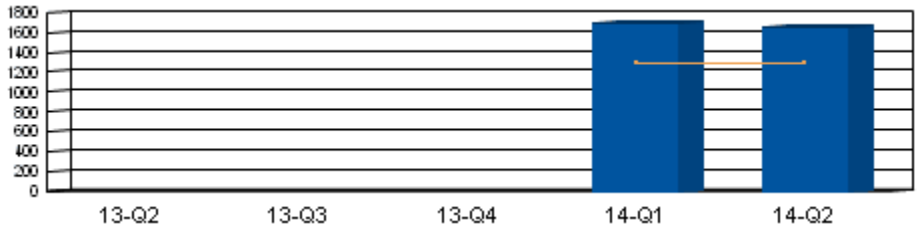
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Reduce the Number of Avoidable Admsisions



	Actual	Target
13-Q2		
13-Q3		
13-Q4		
14-Q1	1,701	**1292**
14-Q2	1,661	**1292**

Interpretation - Patient And Business:

Within KGH, and as part of the Gridlock Value Stream Mapping initiative, there are improvement cycles that focused on eliminating delay with assessments of patients in ED and decision making about admission with the thought that this could reduce admissions that can at times be made for convenience versus compelling clinical need; and also to look at discharge planning processes that will ensure better engagement of community based supports to sustain health in the community and minimize risk of readmissions. This work will continue in Q3.

In Q2, the Patient Flow Task Force has focused on ways to make this avoidable admission data more relevant to individual programs/services and useful for CI work. Work continues on examining patterns or trends with different services and Case Mix Groups (CMG's).

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 internal 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: DATA: Decision Support COMMENTS: Eleanor Rivoire

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

Kingston General Hospital

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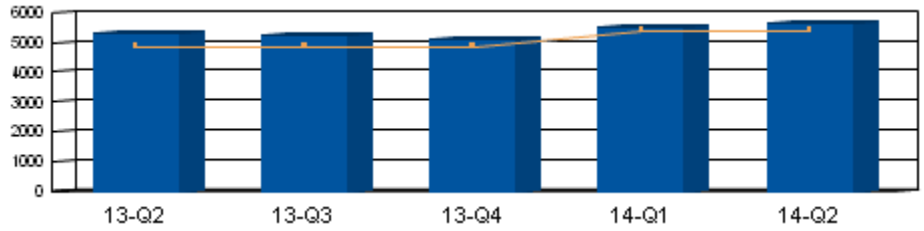
Transform the patient experience through a relentless focus on quality, safety and service

The top sources of GRIDLOCK are addressed.

Indicator: Total Inpatient Admissions



	Actual	Target
13-Q2	5,284	**4850**
13-Q3	5,256	**4850**
13-Q4	5,130	**4850**
14-Q1	5,514	**5398**
14-Q2	5,671	**5398**

Interpretation - Patient And Business:

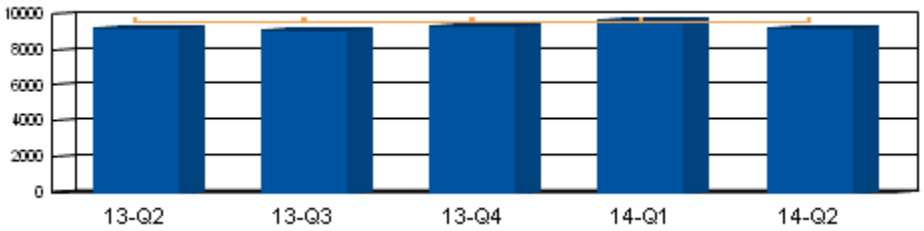
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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

Indicator: Total Inpatient Weighted Cases



	Actual	Target
13-Q2	9,172	**9556**
13-Q3	9,080	**9556**
13-Q4	9,272	**9556**
14-Q1	9,609	**9579**
14-Q2	9,140	**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

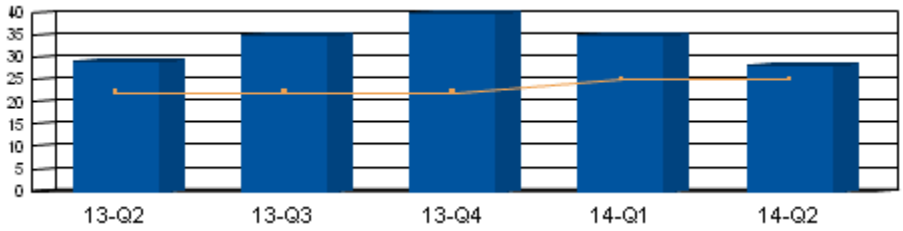
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q2	29	**22**
13-Q3	35	**22**
13-Q4	40	**22**
14-Q1	35	**25**
14-Q2	28	**25**

Interpretation - Patient And Business:

The Q2 result of 28 hours is 3 hours longer than the 25 hour target. Ninety percent of all patients admitted through the ED wait up to 28 hours to be moved to an inpatient bed. Ten percent wait longer than this. This is an improvement of 7 hours over last fiscal.

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.
Working groups are looking at consultant arrival times and processes around decision to admit as priorities 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

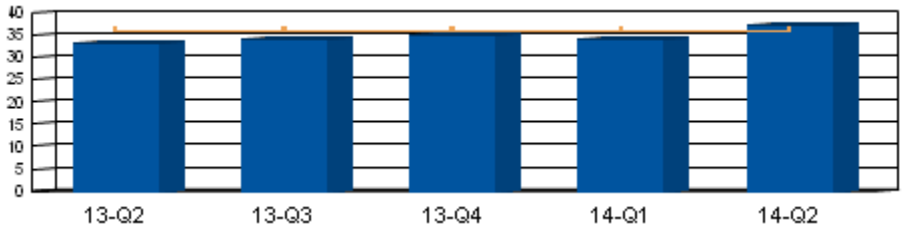
Kingston General Hospital

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-Q2	33	**36**
13-Q3	34	**36**
13-Q4	35	**36**
14-Q1	34	**36**
14-Q2	37	**36**

Interpretation - Patient And Business:

At the end of Q2, 37 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. Q2 had an admission rate of 20% of all ED visits.
Emergency Department admitted patient volumes are above target by 412 admissions this quarter. Inpatient bed days are 1000 days in Q2.
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. Work from the Gridlock value stream map is ongoing with time for decision to admit as one initiative.

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%

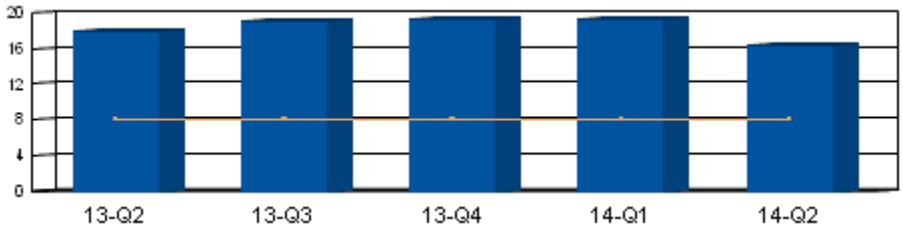
Kingston General Hospital

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-Q2	17.9	**8**
13-Q3	19.0	**8**
13-Q4	19.3	**8**
14-Q1	19.3	**8**
14-Q2	16.3	**8**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for patients admitted with complex conditions is 16.3 hours. Nine of ten patients are moved to an inpatient bed within 16.3 hours of arrival to the department while 10 percent wait longer than 16.3 hours. This is an improvement of 3 hours over Q1. Inpatient days are at 1000 days in Q2 compared to 1071 days same period last year.

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 started.

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

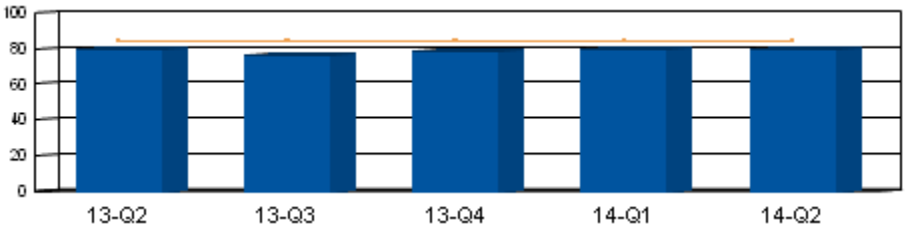
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on Q2 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 1000 days. 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%

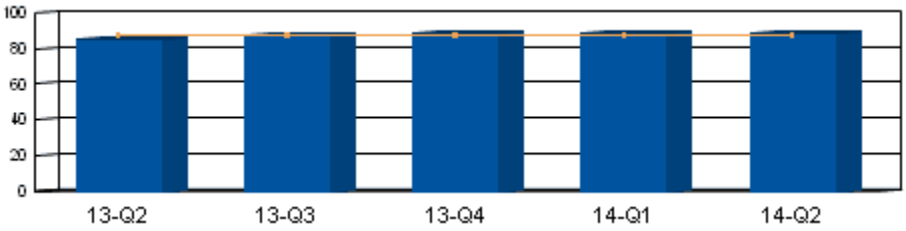
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on the Q2 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 4 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%

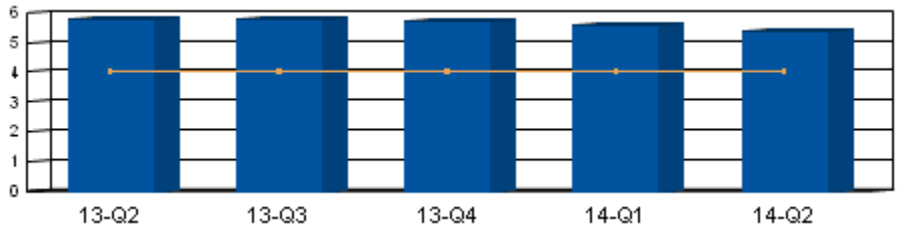
Kingston General Hospital

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-Q2	5.8	**4**
13-Q3	5.8	**4**
13-Q4	5.7	**4**
14-Q1	5.6	**4**
14-Q2	5.4	**4**

Interpretation - Patient And Business:

Based on the Q2 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 5.4 hours. However, this is trending positively and is the best result we have had sine Q2 10/11. 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:

Daily huddles have started to occur with ED staff to begin identifying opportunities for improvement using real time data from EDIS. A project manager has been hired 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

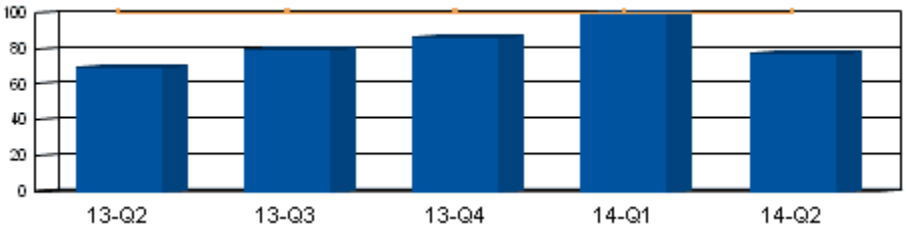
Kingston General Hospital

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 Wait Time Contracted Volumes Achieved



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

Interpretation - Patient And Business:

As of Q2, 10 of 13 Wait Time Contracted volumes were on track. The three that are not tracking accordingly are a focus of the SPA program.

Actions & Monitoring Underway to Improve Performance:

Tremendous leadership by the SPA, Cardiac and Diagnostic Imaging programs continues in an effort to manage these volumes and hit these targets.

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?** The work planned for Q2 continues, with goal of launching auditing of standards in Nov/13. A steering group oversees the planning, with teams working on each of the 5 standards. There was decision made to shift from use of AIDET as a customer service approach to one used by the Cleveland Clinic (Communicate with HEART). This approach is preferred because it can be aligned to processes that support communication, risk management and leadership development.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Work focuses on ensuring that the infrastructure and education is in place for use of white boards; conducting patient led forums; hourly rounding; wearing ID badges and with customer service behaviours, and to ensure staff are aware of the launch of the audit process. There has been design of the electronic tool for auditing the standards and putting in place a system to sustain the auditing process. Patient led forums have been scheduled and are being conducted in every program.

3. **Are we on track to meet the milestone by year end?** Yes. While planning/implementation of the Cleveland Clinic program may be delayed until Q4, the team plans to start auditing the patient experience / perception in relation to customer service standards and this will provide some baseline information to support the customer service.

4. **What new tactics are planned to ensure this milestone is met?** Q3 will focus on the launch of the auditing and reporting to programs/services, along with the planning for the launch of the Communicate with HEART program ideally in Q4.

Kingston General Hospital

MS #04

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2
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	G	G

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

Kingston General Hospital

MS #04

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

Interpretation - Patient And Business:

The project team continues to meet. Individual teams continue to support each of the 5 standards. Communication of the standards continues. Auditing tool is ready to be tested.

Actions & Monitoring Underway to Improve Performance:

We will continue to communicate expectations to all staff and physicians and offer support where needed. Educational materials are being completed. Roll out will begin mid-November. Auditing will begin Nov 30th.

Definition: DATA: Dino Loricchio 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 by 45% Yellow

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?**

   Externally funded research has increased by 43% (yellow) since baseline.

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 by external service provider. External service provider creating KGHRI strategic plan and KGHRI report (*summarizing the accomplishments of our first three years as a Research Institute*): *expect both reports to roll out by end of Q3. RFP for KGH website, which includes KGHRI website, gone out. Selection of vendor to occur in early November.*

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

   Partnership plans for joint venture enterprise continue: monthly meetings with CEOs, Dean and FHS 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. ***Done***
   - Research Strategic Plan launched. ***Underway***
   - Video researcher profiles of new clinician scientists launched. ***Underway***
   - F2013 Research Report (annual event). ***Underway***
   - KGHRI branding and website development. ***Underway***
   - Communication/marketing plan developed for KGHRI. ***Underway***
   - 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-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
Cultivate patient oriented research	Externally funded research at KGH has increased to 45%	4% Increase of Externally Funded Research Dollars at KGH	G	G	G	R	Y	↑
		Active Clinical Trials	G	G	G	G	G	↑
		Clinical Trials Generating Revenue	G	G	G	G	G	↑
		New Clinical Trials	R	Y	Y	R	R	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

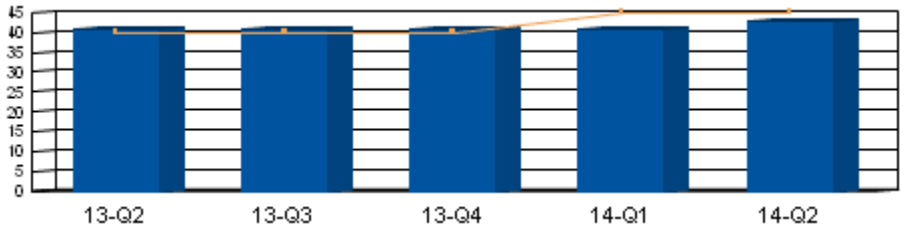
Kingston General Hospital

MS #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-Q2	41	**40**
13-Q3	41	**40**
13-Q4	41	**40**
14-Q1	41	**45**
14-Q2	43	**45**

Interpretation - Patient And Business:

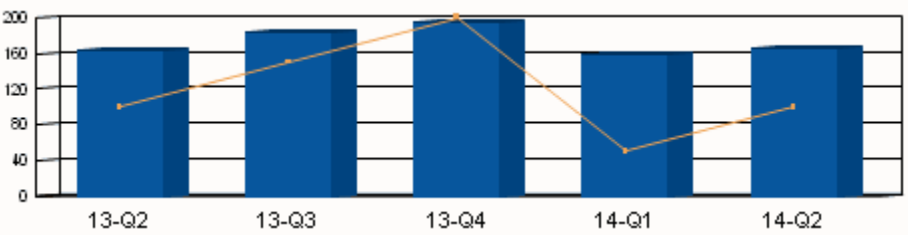
KGH Research Annual Report will be released in November 2013. The data for percent increase in research funds was recorded in Q2. Real F2013 data will be used for reporting of F2014 data for this performance indicator since real figures for F2014 will not be available until September 2014. 95% of the 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-Q2	163	**100**
13-Q3	184	**150**
13-Q4	195	**200**
14-Q1	158	**50**
14-Q2	165	**100**

Interpretation - Patient And Business:

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

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

Definition: 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

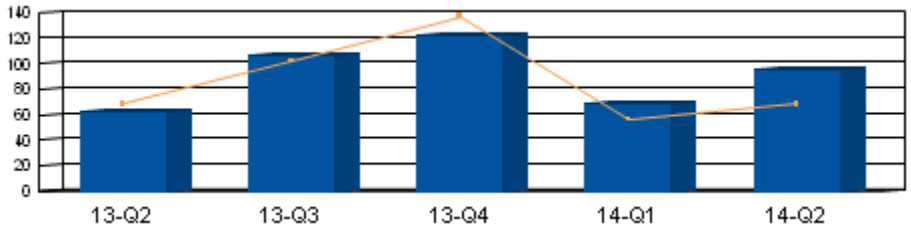
Kingston General Hospital

MS #05

Cultivate patient oriented research

Externally funded research at KGH has increased to 45%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
13-Q2	63	**68**
13-Q3	107	**102**
13-Q4	123	**137**
14-Q1	69	**56**
14-Q2	95	**68**

Interpretation - Patient And Business:

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

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

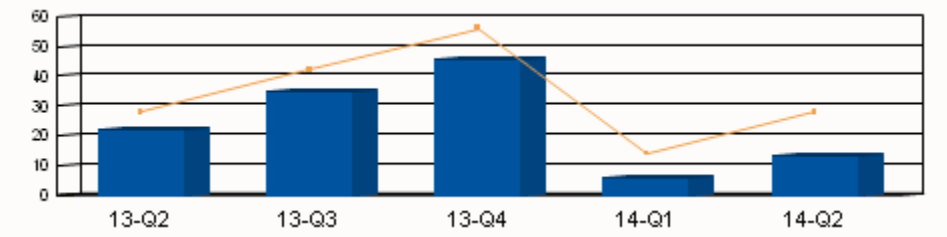
Definition: DATA: Veronica Harris-McAllister COMMENTS: Veronica Harris-McAllister

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

Interpretation - Patient And Business:

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

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

Definition: 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?

19 of 23 indicators are Green or Yellow (86%). QBP Stroke, COPD and CHF all converted to green. QBP Vascular remains red as does the e-discharge, 30 day readmission, and patient waiting for transfer.

QBP Primary Hip and Knee Replacement continues as yellow and may pose a risk to reach the correct mix of Hips and knees and individual targets.

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)

QBP: Teams continue to utilize the toolkit to implement each QBP. Coding concerns address with all groups.
Pt waiting for transfer: Transportation RFP signed off and implementation of service imminent
E-Discharge: JQUIC is getting information to the Departments to provider level.

3. Are we on track to meet the milestone by year end?
Yes. Red will likely continue with 30 day readmissions and e-discharge.

4. What new tactics are planned to ensure this milestone is met?
QBP: SPA leadership working with the Division of Ortho to closely monitor and report on volumes; Vascular readdressing some of the inclusion criteria.
Pt waiting for Transfer: Working with regional partners via SECHEF to address repatriation and gridlock. Provincial Life and Limb Policy includes a repatriation clause.
30 Day Readmission: Partnering through Health Links

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			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	Y	Y	
		The Number of Patients Waiting for Transfer to Other Facilities is Reduced by 50%	N/A	N/A	N/A	R	R	
		Readmission Rate Within 30 Days for Selected CMG's to Any Facility	R	Y	N/A	N/A	N/A	↑
		Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile - (QIP)	Y	G	G	R	R	↓
		QBP (Quality Based Procedure) - COPD	N/A	N/A	N/A	Y	G	
		QBP (Quality Based Procedure) - Heart Failure (CHF)	N/A	N/A	N/A	R	G	
		QBP (Quality Based Procedure) - Primary Hip & Knee Replacement Volume	G	G	G	Y	Y	↓
		QBP (Quality Based Procedure) - Stroke	N/A	N/A	N/A	R	G	
		QBP (Quality Based Procedure) - Vascular	N/A	N/A	N/A	R	R	
		Ambulatory Care Volumes	G	G	G	G	G	↑
		Cardiac - Angiography Volumes	G	G	G	G	G	↑
		Cardiac - Angioplasty Volumes	G	G	Y	Y	Y	↓
		Cardiac - Bypass Volumes	G	Y	G	G	G	↑
		CT Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑
		MRI Hours (Wait Time Strategy Allocation)	G	G	G	G	G	↑

	13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	Y	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 ↓

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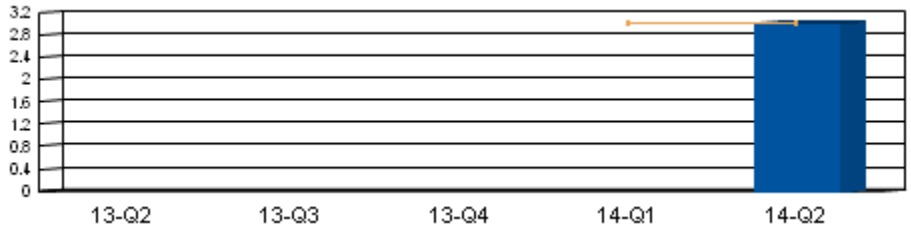
Increase our focus on complex-acute and specialty care

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

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

Actions & Monitoring Underway to Improve Performance:

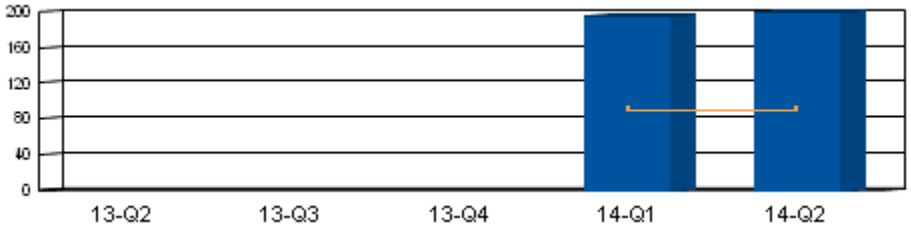
1. Patient Repatriation Transfer: Transfers to intra-LHIN hospitals requires frequent prompting to initiate activity. Upcoming transportation agreement is expected to help expedite and simplify transfers.
2. 30 day readmission rates: Data is in process of formatting to present to JQUIC.
3. QBP: Teams have all begun setting up processes of analyzing coding a key component to ensuring all appropriate data is captured.

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-Q2		
13-Q3		
13-Q4		
14-Q1	194	**90**
14-Q2	199	**90**

Interpretation - Patient And Business:

Delayed transfers of patients to their home institution is a contributor to decreased patient flow and gridlock. A Repatriation Policy via the LHIN's SECHEF (leadership group) and a new nonurgent transportation system has had little implact.

Actions & Monitoring Underway to Improve Performance:

Additional concerted energy and effort by the regional partners will be needed to effectively improve patient flow to and from KGH.

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

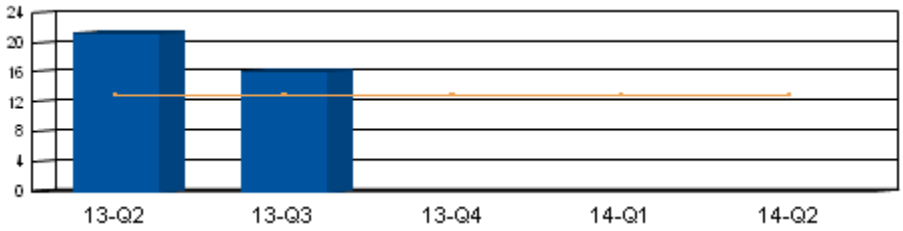
Kingston General Hospital

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-Q2	21.2	12.9
13-Q3	16.1	12.9
13-Q4		12.9
14-Q1		12.9
14-Q2		12.9

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

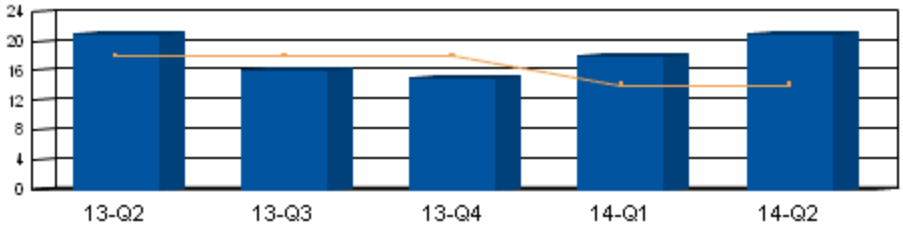
The data is supplied to KGH from the MOH and generally will be 3 quarters behind. The current rate of 16.1 is above the target of 12.9 but down significantly from the previous quarter going from red to yellow status. An in-depth concurrent review on all hospital readmissions is planned for Q3 and will reviewed by Departmental Quality committees as well as the Joint Quality and Utilization Committee and the Patient Safety and Quality Committee. It is also worth noting that this indicator is part of the KGH QIP for fiscal 12/13

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

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-Q2	21	18
13-Q3	16	18
13-Q4	15	18
14-Q1	18	14
14-Q2	21	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%

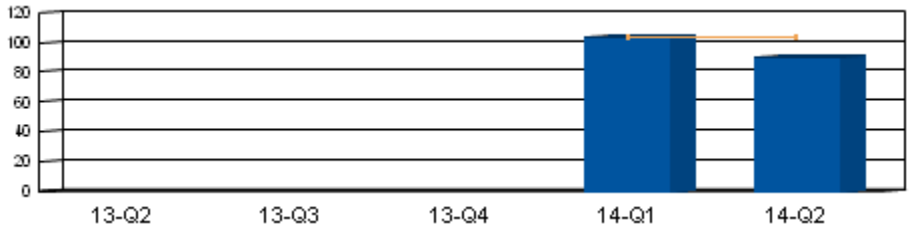
Kingston General Hospital

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-Q2		
13-Q3		
13-Q4		
14-Q1	104	**103**
14-Q2	90	**103**

Interpretation - Patient And Business:

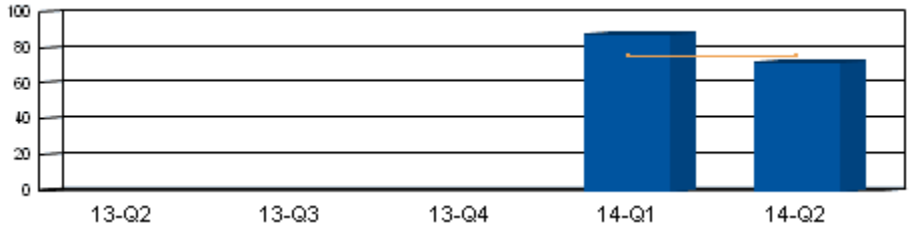
At the end of Q2 admissions of patients who have a COPD (typically an exacerbation of this condition) is as expected. The results show projected volume-based implementation of the QBP for COPD, the qualifying cases (target) compared with actual

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

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



	Actual	Target
13-Q2		
13-Q3		
13-Q4		
14-Q1	87	**75**
14-Q2	72	**75**

Interpretation - Patient And Business:

At the end of Q2 patient volumes with a diagnosis of Heart Failure are within normal limits. 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'.
An improvement team is working on maximizing the quality of care and care plans within this patient population.

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

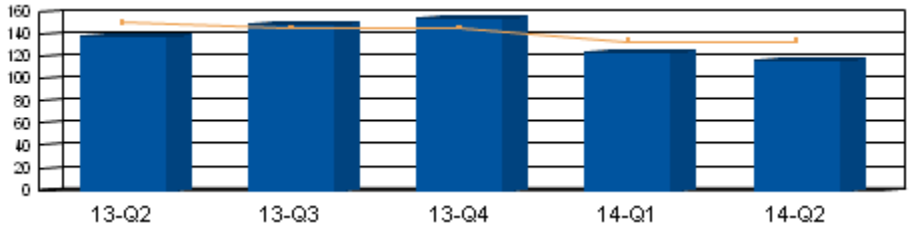
Kingston General Hospital

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-Q2	138	**150**
13-Q3	148	**145**
13-Q4	154	**145**
14-Q1	124	**133**
14-Q2	116	**133**

Interpretation - Patient And Business:

For Q2 YTD there have been 118 primary hip replacement surgeries completed of the end of year target of 194 funded cases. Also there have been 122 primary knee replacements completed YTD of the end of year funded target of 338 cases. If this trend is to continue then primary hip volumes will be over the target (21 unfunded) and primary knees will be potentially short by 50 cases.

Total hip/ knee revisions have a funded target volume of 112 cases and currently there have been 77 completed YTD.

Actions & Monitoring Underway to Improve Performance:

SPA leadership and the QBP working group are closely monitoring the volumes with the recognition that activity will need to be put on hold if certain procedures have exceeded their case volumes. This will have an impact on wait times for this population.

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

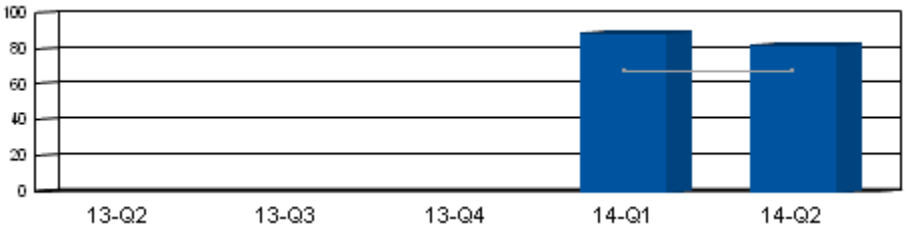
Kingston General Hospital

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-Q2		
13-Q3		
13-Q4		
14-Q1	88	**67**
14-Q2	82	**67**

Interpretation - Patient And Business:

At the end of Q2 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. 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'. An improvement team has been established and is working on cycles to improve services within the service area.

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

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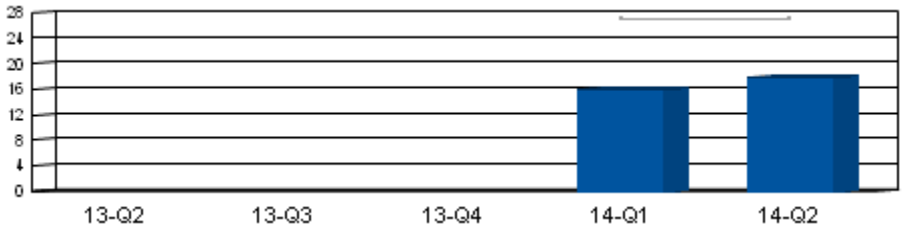
Increase our focus on complex-acute and specialty care

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

Indicator: QBP (Quality Based Procedure) - Vascular



	Actual	Target
13-Q2		
13-Q3		
13-Q4		
14-Q1	16	**27**
14-Q2	18	**27**

Interpretation - Patient And Business:

For Q2 there were 11 Acute inpatient Non-Cardiac Vascular Aortic Aneurysm (AA) completed. This has raised our volumes to 22 cases YTD with an end of year funded target of 61 cases.

For the second acute inpatient Non-Cardiac Vascular Lower Extremity Occlusive Disease (LEOD) QBP there were 9 completed cases in this quarter with a total of 12 cases YTD. The current QBP year-end funded target for LEOD procedures is 46 cases.

Actions & Monitoring Underway to Improve Performance:

In review of the criteria for identifying qualified funded cases, the QBP working group and SPA leadership will be reviewing these QBP case volumes to ensure that cases are coded properly by the interprofessional team.

Due to the elective activity focus of these two QBP's funded volumes there is a risk that KGH will not be able to achieve the year-end target as majority of case work is urgent/emergent activity.

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

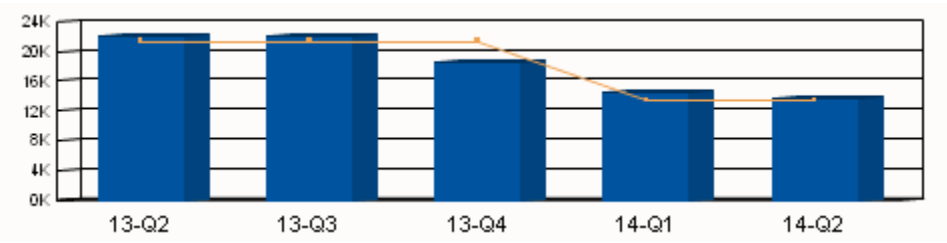
Kingston General Hospital

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: Ambulatory Care Volumes



	Actual	Target
13-Q2	22,085	**21323**
13-Q3	22,068	**21323**
13-Q4	18,613	**21323**
14-Q1	14,551	**13386**
14-Q2	13,787	**13386**

Interpretation - Patient And Business:

This activity continues to meet the new clinic target corridors. Discussion regarding the remaining clinic transfers in underway which will potentially influence the next quarter's volumes

Actions & Monitoring Underway to Improve Performance:

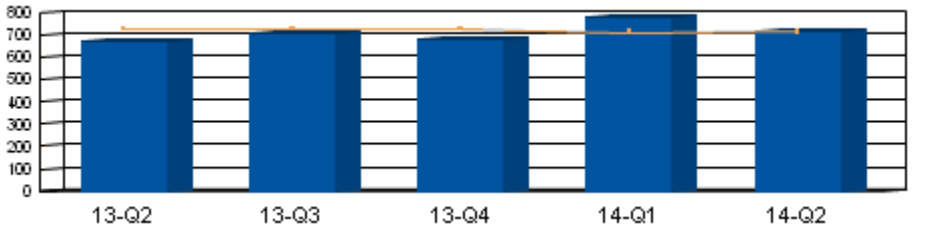
Working with the cardiac service and renal service to determine transfer dates to their new locations.

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

Indicator: Cardiac - Angiography Volumes



	Actual	Target
13-Q2	674	**725**
13-Q3	711	**725**
13-Q4	678	**725**
14-Q1	776	**712**
14-Q2	717	**713**

Interpretation - Patient And Business:

Cardiac Angiography volumes are above the target volumes in Q2. Procedures are being done well within the recommended wait times for all angiography.

Actions & Monitoring Underway to Improve Performance:

On track to meet funded volumes for 2013/14.

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: 2,850

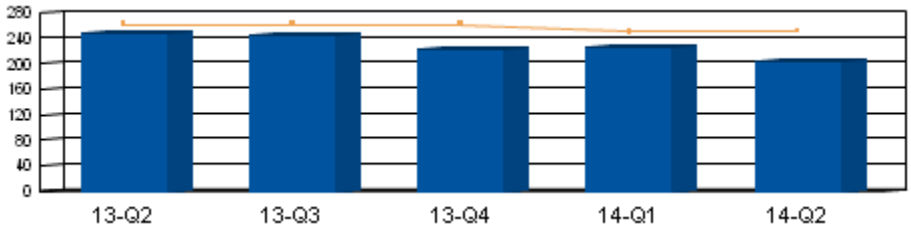
Kingston General Hospital

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-Q2	248	**262**
13-Q3	244	**262**
13-Q4	222	**262**
14-Q1	227	**250**
14-Q2	204	**251**

Interpretation - Patient And Business:

Cardiac Angioplasty volumes are below target in Q2. Angiography volumes remain on target and 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 when appropriate.

Actions & Monitoring Underway to Improve Performance:

While angiography volumes remain constant, angioplasty volumes are trending down. Historically, approximately 30% of angiographies lead to angioplasty which is in line with the provincial average. Q2 rate is 28%. This would suggest that more angiographies than usual are not resulting in angioplasty.

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: 1,000

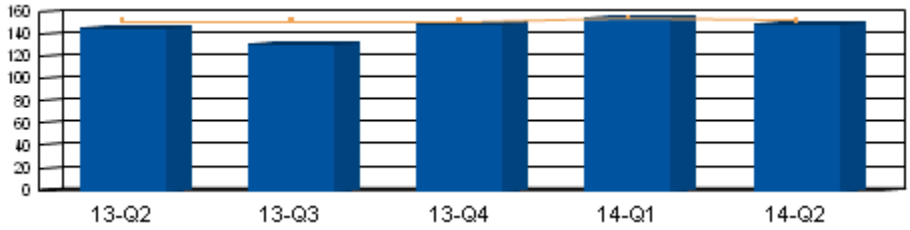
Kingston General Hospital

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-Q2	145	**151**
13-Q3	131	**151**
13-Q4	148	**151**
14-Q1	155	**154**
14-Q2	149	**152**

Interpretation - Patient And Business:

Cardiac surgery volumes are trending on target volumes at the end of Q2. 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 was a concern in Q2 as there was a loss of operating room time during July and August.

Actions & Monitoring Underway to Improve Performance:

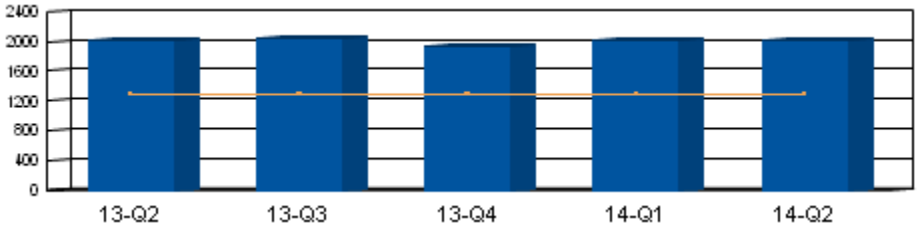
Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Programs and the Wait Times Committee in order to achieve target volumes and wait times and to mitigate cancellations. Surgical volumes and wait times are monitored by the Cardiac Care Network (CCN) of Ontario. The monthly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

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: 610

Indicator: CT Hours (Wait Time Strategy Allocation)



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

Interpretation - Patient And Business:

The combined operational hours of the 2 CT's exceed the target. This is required to meet the needs of the organization. No change in practice.

Actions & Monitoring Underway to Improve Performance:

Continue with present operational hours and plan.

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

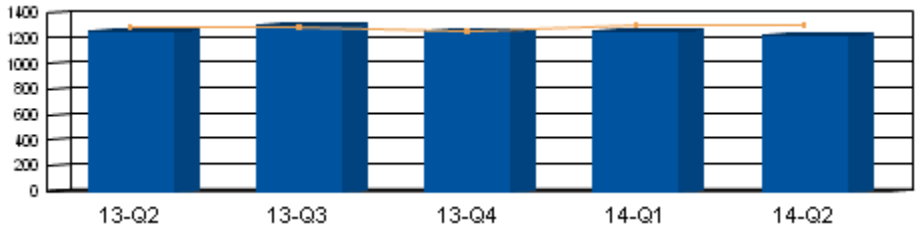
Kingston General Hospital

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-Q2	1,250	**1283**
13-Q3	1,298	**1283**
13-Q4	1,257	**1250**
14-Q1	1,254	**1300**
14-Q2	1,221	**1300**

Interpretation - Patient And Business:

High number of sick time hours has resulted in a decrease of operational hours. Staff members are being managed through Attendance Awareness and performance management. 2 additional PT staff members have been hired.

A decrease in operational hours increases wait time. It puts more patients at risk. It also results in staff members working alone for more hours than is recommended.

Potential loss of wait time funding.

Actions & Monitoring Underway to Improve Performance:

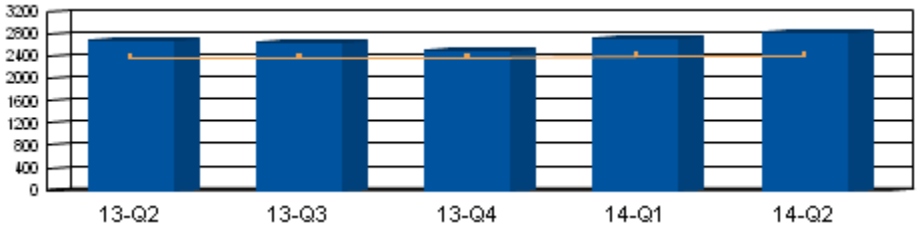
Plan to expand hours when new staff are on-site to ensure we achieve hours by March 31st, 2014.

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-Q2	2,683	**2370**
13-Q3	2,657	**2370**
13-Q4	2,520	**2370**
14-Q1	2,736	**2416**
14-Q2	2,828	**2416**

Interpretation - Patient And Business:

Emergency Department admitted patient volumes are above target by 412 admissions at the end of Q2. Admitted patient volumes for the ED in Q2 are 145 admissions more than same period last year.
On average, 19% of all visits to the ED result in admission. Q2 result is 20%.

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. Work is also being done to ensure repatriation to other centers occurs in a timely fashion which will create capacity.

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

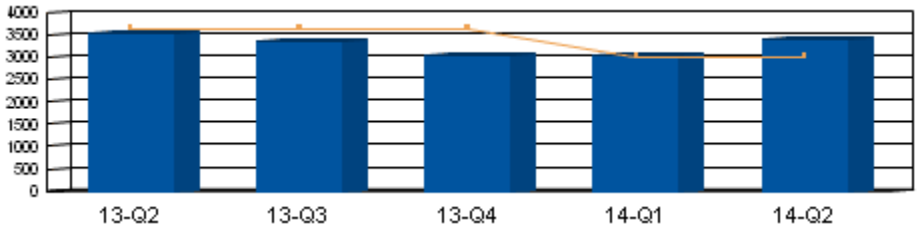
Kingston General Hospital

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-Q2	3,547	**3647**
13-Q3	3,349	**3647**
13-Q4	3,028	**3647**
14-Q1	3,054	**3011**
14-Q2	3,411	**3011**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

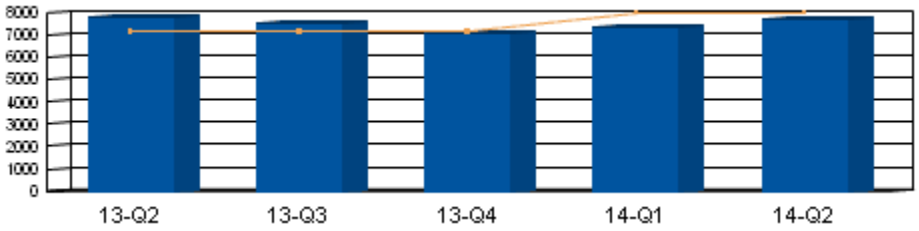
The volume of ED visits in this category had been appropriately decreasing over the previous 2 quarters indicating that patients requiring less urgent medical attention are utilizing resources other than the ED. However, volumes were up significantly in Q2, 400 more visits that Q1 but 136 fewer visits than Q2 last fiscal.

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-Q2	7,766	**7149**
13-Q3	7,575	**7149**
13-Q4	7,045	**7149**
14-Q1	7,345	**7994**
14-Q2	7,755	**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 Q2 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

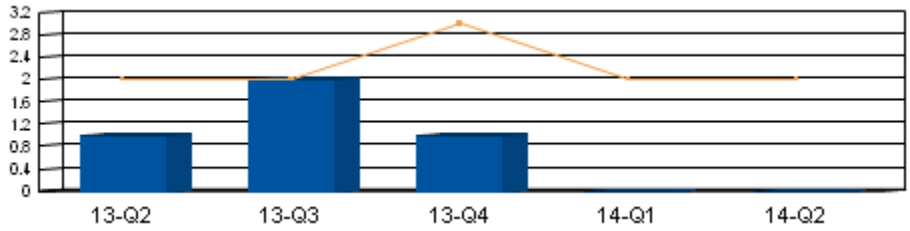
Kingston General Hospital

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

Interpretation - Patient And Business:

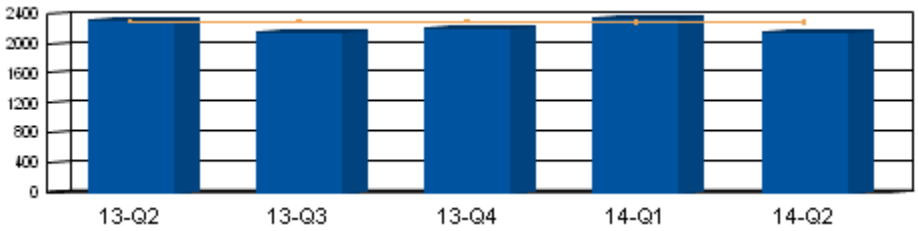
Kidney transplant numbers are driven most significantly by the availability of organs donated through deceased patients.

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-Q2	2,311	**2286**
13-Q3	2,159	**2286**
13-Q4	2,208	**2286**
14-Q1	2,329	**2282**
14-Q2	2,150	**2282**

Interpretation - Patient And Business:

For Q2 this indicator continues to meet the green target corridor although operating room activity was decreased from 11 operating rooms to 9 functioning rooms during the months of July and August due to human resources vacancies.

Actions & Monitoring Underway to Improve Performance:

The SPA program has been offering a Perioperative Hybrid operating room course (10 candidates) in partnership with Algonquin College which will assist in addressing the staffing vacancies in future.

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

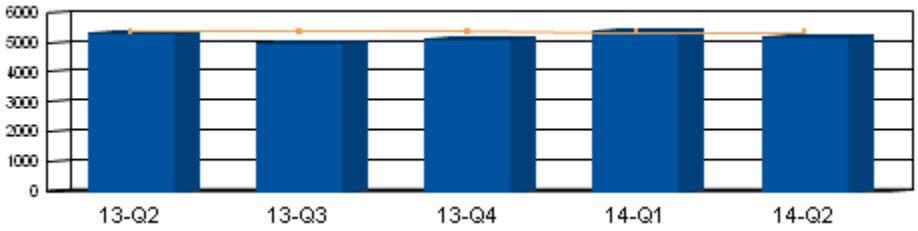
Kingston General Hospital

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-Q2	5,332	**5345**
13-Q3	5,004	**5345**
13-Q4	5,114	**5345**
14-Q1	5,390	**5332**
14-Q2	5,173	**5332**

Interpretation - Patient And Business:

For Q2 this indicator continues to meet the green target corridor although operating room activity was decreased from 11 operating rooms to 9 functioning rooms during the months of July and August due to human resources vacancies.

Actions & Monitoring Underway to Improve Performance:

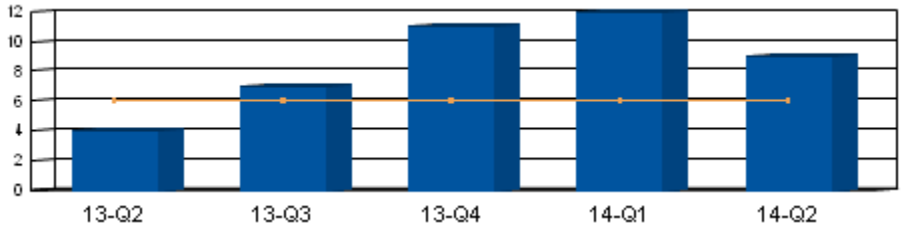
The SPA program has been offering a Perioperative Hybrid operating room course (10 candidates) in partnership with Algonquin College which will assist in addressing the staffing vacancies in future.

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-Q2	4	**6**
13-Q3	7	**6**
13-Q4	11	**6**
14-Q1	12	**6**
14-Q2	9	**6**

Interpretation - Patient And Business:

At the end of Quarter 2, KGH has performed 21 stem cell transplants to date for Fiscal 2014. We are currently exceeding the target of 6 per quarter.

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

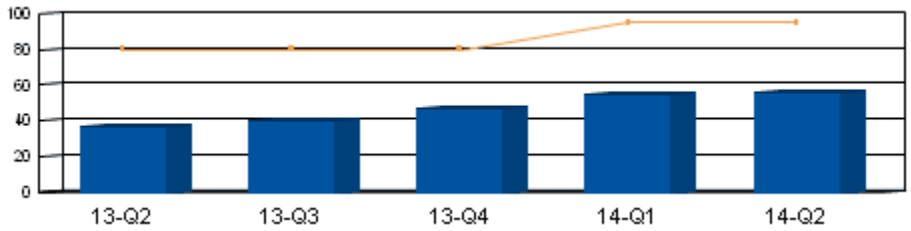
Kingston General Hospital

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-Q2	37	**80**
13-Q3	40	**80**
13-Q4	47	**80**
14-Q1	55	**95**
14-Q2	56	**95**

Interpretation - Patient And Business:

Second quarter results of 56% represents minimal change over the previous quarter. Overall chart deficiencies remain within target and continue to support timely data submissions.

Actions & Monitoring Underway to Improve Performance:

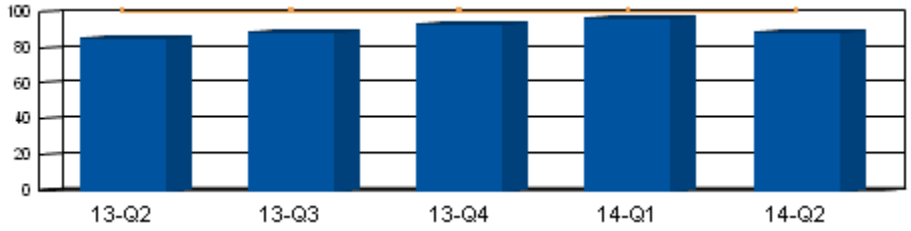
Data continues to be supplied to the Clinical Department's Quality Committees. The data drives down to the level of the individual physician. Re-engaging through JQUIC and MAC will be needed to spotlight the gap.

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-Q2	85	**100**
13-Q3	89	**100**
13-Q4	93	**100**
14-Q1	96	**100**
14-Q2	88	**100**

Interpretation - Patient And Business:

As of Q2, 3 of 26 contracted volume indicators had Red status. They are General Surgery - Anorectal, Plastic Surgery - Maxiofacial, and Paeds Cleft Lip.

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 have achieved what was set out in the tactic plan. Engagement survey results received in Q2 and roll out plan and support materials were developed. Survey interpretation sessions were provided to the KGH Leadership Team and additional support was provided via one-on-one coaching with leaders. A presentation on the corporate results was delivered in September to the KGH Leadership Group and the Local Union Presidents. Effective Team Leadership pilot was conducted. This series of 4X2 hour sessions entailed the establishment of coaching contracts and regular coaching sessions of participants. A proposal for a revamped recognition program was reviewed by Operations and feedback was obtained from a number of frontline staff. The rolling average 12 month sick time increased from 11.3 to 11.5 days however, the month of August did hit target levels.

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)
   - Staff survey preparation and execution to inform planning, followed by training of leaders and role out of engagement activities. This has been accomplished.
   - Physician survey completion, shared through the Clinical Department Heads and physicians via presentations. Corporate plan will also be developed in conjunction with a Physician Engagement Strategy. In Q2 all Medical Department Heads received results to then share with their physicians.
   - Develop curriculum/components, automation and implementation plan for the Leadership Development Program. A pilot program has been launched.
   - Launch and implement a formal talent review and succession plan. This was put on hold pending support for automation from Information Management.

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

4. **What new tactics are planned to ensure this milestone is met?**
A number of initiatives continue to roll-out to support this milestone. In Q3, the online Targeted Talent Solutions website (TTS) and 2-day workshops on Leading for Engagement will be launched and provided to members of the KGH Leadership Group. Leaders are required to share team results by the end of October. Debrief of the corporate results will be conducted with key employee groups, such as “Worklife@KGH” and “Nursing Practice Council”. Engagement Action Planning with individual employee eams starts in November. Director, Medical Affairs, to meet with physicians to solicit more feedback on how to improve engagement . The second series of Effective Team Leadership will be offered. Exploration regarding usage of SAP for Succession Planning and Talent Management will commence.

Kingston General Hospital

MS #07

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	G	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	R	R	Y	G	G	↑
		Percent Sick Time Hours	Y	R	Y	Y	Y	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

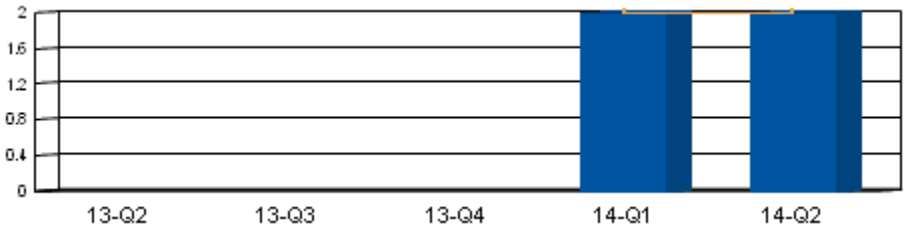
Kingston General Hospital

MS #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-Q2		
13-Q3		
13-Q4		
14-Q1	2	**2**
14-Q2	2	**2**

Interpretation - Patient And Business:

On track. Engagement survey results were obtained, analyzed and presented to leadership. Planning and tactics team continued in Q2 for staff roll out of results. Communication to staff of Corporate results initiated. Interpretation training occurred for leaders and supports in place.

Actions & Monitoring Underway to Improve Performance:

Staff team results roll out by leaders in Q3. Training sessions for leaders to take action scheduled and corporate results to be available on Intranet. Targeted Talent Solutions website launched for leaders to support improvements and action plan development.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima

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

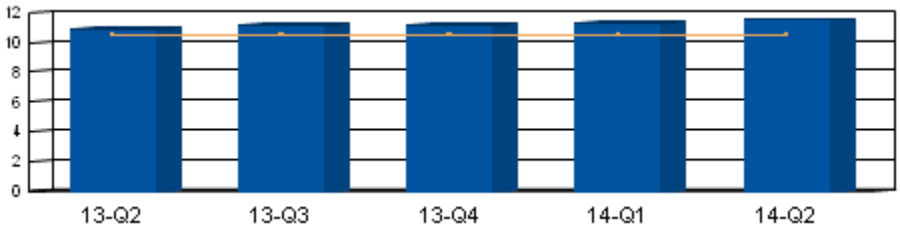
Kingston General Hospital

MS #07

People

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

Indicator: Average Sick Days per Eligible Employee Per Year



	Actual	Target
13-Q2	10.9	**10.5**
13-Q3	11.1	**10.5**
13-Q4	11.1	**10.5**
14-Q1	11.3	**10.5**
14-Q2	11.5	**10.5**

Interpretation - Patient And Business:

The rolling average for the end of the second quarter was 11.47 average days per employee per year. This is not at target levels; however the number of incidents remains stable. Although the average did not meet target, the month of August did hit target levels that may be influenced by the ability to take prime vacation time.

Actions & Monitoring Underway to Improve Performance:

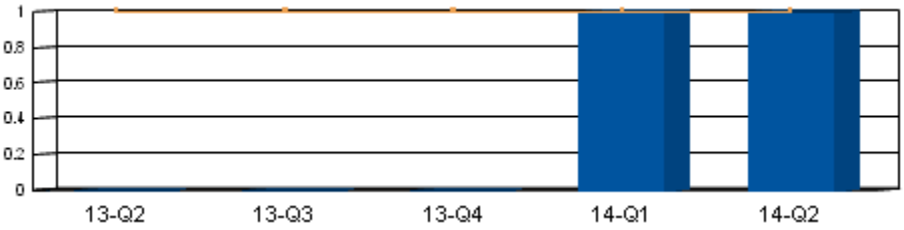
The number of employees in the attendance program has decreased by 8.3% from September 2012 which places the continued focus on health and wellness activities. On site fitness was introduced in the quarter and other programs targeting mental health, smoking cessation and influenza will be key initiatives in Q3.
The potential new language if ratified introduced into the CUPE Collective Agreement will have a significant impact on the hospital Attendance Management Program and will also be under review.

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

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



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

Interpretation - Patient And Business:

On Track. Roll out expected to staff at team level in Q3. Corporate results released and posted on Intranet. Leader interpreting results sessions occurred in September.

Actions & Monitoring Underway to Improve Performance:

Training for leaders in developing action plans scheduled for Q3. Folders for directors and website created with tools for roll out at team levels.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima

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

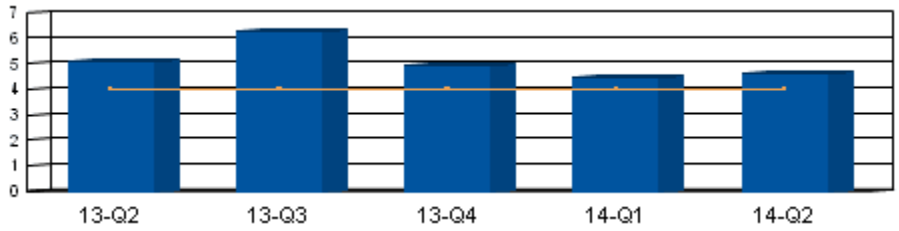
Kingston General Hospital

MS #07

People

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

Indicator: Percent Sick Time Hours



	Actual	Target
13-Q2	5.1	**4**
13-Q3	6.3	**4**
13-Q4	4.9	**4**
14-Q1	4.5	**4**
14-Q2	4.6	**4**

Interpretation - Patient And Business:

Although the rolling average was not at target levels (11.47), the month of August did hit target levels that may be influenced by the ability to take prime vacation time.

Actions & Monitoring Underway to Improve Performance:

The number of employees in the attendance program has decreased by 8.3% from September 2012 which places the continued focus on health and wellness activities. On site fitness was introduced in the quarter and other programs targeting mental health, smoking cessation and influenza will be key initiatives in Q3.
The potential new language if ratified introduced into the CUPE Collective Agreement will have a significant impact on the hospital Attendance Management Program and will also be under review.

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

Yellow

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?

Of the 20 H&S indicators, 13 are green/yellow. Significant drop in the Management Inspection Program (64% versus 84% in Q1 – target is 80%); Respirator Fit Testing (75% versus 83 % in Q1 – target is 100%); Mandatory Safety Training (84% versus 91% in Q1 – target is 100%); and Management Incident Investigations (84% versus 93% in Q1 – target is 100%). While Needlestick injuries increased from 9 in Q1 to 17 in Q2 – target is less than 12.

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)

- Review current practices for preventing violence in the workplace and assess/revise Behavioural Crisis Alert (BCA) Process for communication of patient violence. The tactical team has regular meetings and a value stream mapping was completed. Working with Emergency to include BCA into the checklist.
- Based SAFE reporting data address the top 3 causes of staff Slips/Trips/Falls and MSI and needlesticks, then implement improvements to address them. Slips/Trips/Falls: A tactical team was formed in Q2 and in process of data analysis. MSI: The tactical team has linked with the corporate patient falls team and work is continuing. Renewing the MSI online training module and have traied new transfer boards. Needlesticks: A change in team membership is required due to staff changes, and data analysis is underway.

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

We still believe that we are on track to meet this milestone by March 31st. In Q1 the scorecard was green and we tend to hit a slowdown for follow-up over the summer months due to vacations. It will be important to ensure that Executives remind Directors that action is required by all leaders.

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

Set up of centrally located fit testing for staff in November to make more accessible. Provide Executives with lists of departments in non-compliance with mandatory safety training for follow-up. Presentation to the Leadership Forum to reinforce accountabilities in November. Revision of the workplace injury kit and a Safety Talk bulletin will be sent to staff in November on roles and responsibilities related to workplace safety and injury management. Supervisory competency training to be rolled out via LMS to frontline leaders and up by the end of November.

Kingston General Hospital

MS #08

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2
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	G	Y
		Number of Health & Safety Scorecard Target Indicators Met	R	R	G	G	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

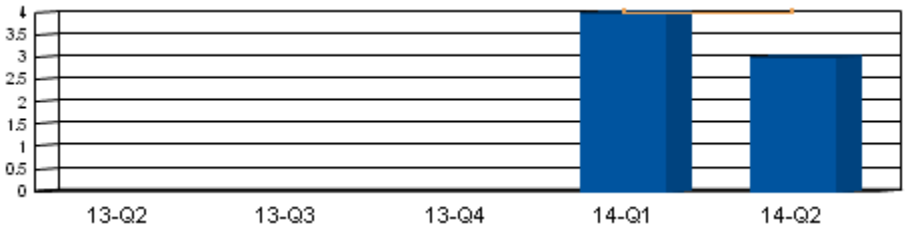
Kingston General Hospital

MS #08

People

The top sources of preventable harm to staff are addressed

Indicator: Number of Preventable Harm to Staff Indicators are Met



	Actual	Target
13-Q2		
13-Q3		
13-Q4		
14-Q1	4	**4**
14-Q2	3	**4**

Interpretation - Patient And Business:

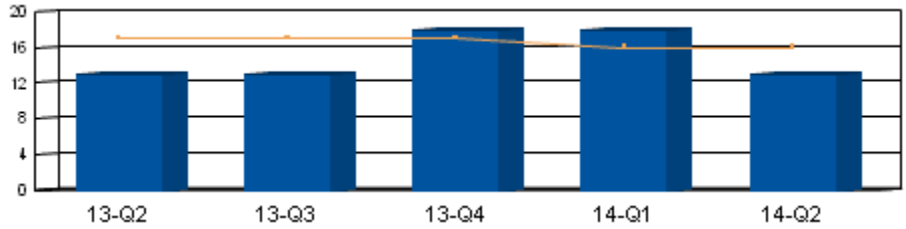
NSI prevention tactic recently re-assigned and tactic work has re-commenced.

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

Interpretation - Patient And Business:

13 measures on/approaching target (green & yellow).
Indicators in red include:
-respirator fit testing completion
-incidence of needlestick injuries
-percent completion of management incident investigations, management inspections, and management 21 day response to JHSC inspection recommendations.
-Completion of mandatory safety training
-Lost time severity rate- a factor of the days lost due to workplace

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?

17/24 Improvement Priorities are actively using continuous improvement principles & PDSA improvement cycles. The remaining seven are in the preliminary stages of team development or not yet initiated, but intend to use continuous improvement principles as work commences in the Plan stage.

The following 7 unique fiscal 13-14 improvement priorities that are not actively using a PDSA improvement cycle are governed by a well articulated project plan or established process:

- Advance the plan for a Kingston-wide health research enterprise
- Increase the profile of KGH research
- Support Phase 2 redevelopment by developing a culture of philanthropy at KGH and obtaining approval for Stage 2
- Improve internal hospital wayfinding
- Increase our capital spend to $17.5 million
- Prepare the organization to support Health System Funding Reform

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 Two our focus was on Planning and Doing. We:
    - Provided “introduction to continuous improvement training” to improvement priority team members as nominated by KGH Leaders, including Patient Experience Advisors. We trained 64 staff and 10 Patient Experience Advisors throughout July, August and September.
    - Developed and launched an interactive and searchable PDSA Library to track all PDSA’s across KGH and enable the sharing of best practices.
    - Worked with the Executive sponsors to ensure they are comfortable with and consistently use the standardized tool introduced last quarter for them 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. Feedback on this tool confirmed that they are better able to track progress and identify & address barriers to success more quickly with their teams.

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?

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

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

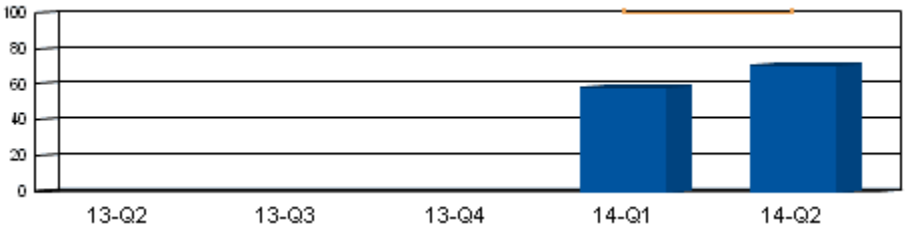
Kingston General Hospital

MS #09

Processes

Adoption of continuous improvement principles is increased

Indicator: Number of Improvement Priorities Using PDSA Improvement Cycles



	Actual	Target
13-Q2		
13-Q3		
13-Q4		
14-Q1	58	**100**
14-Q2	71	**100**

Interpretation - Patient And Business:

17 out of 24 Improvement Priorities (71%) are actively using continuous improvement principles and PDSA improvement cycles. The remaining 7 are in preliminary stages of team development or not yet initiated but intend to be continuous improvement principles as work commences in the Plan stage.

Definition: 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. Based on their initial review of our Stage 1 submission, the Ministry has requested additional information related to surgical capacity and plans for HDH and KGH. This is still a work in progress and we continue to work towards obtaining approval by the end of the fiscal year.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
The SE LHIN confirmed in Q2 the nature of the work required by the MoHLTC Capital Branch and JPO has prepared an approach and obtained a proposal from our consultant to complete the required report. On November 6, 2013 a meeting has been arranged with HDH and the SE LHIN to obtain approval to proceed with obtaining the required report.

   On the related improvement priorities we continue to advance work with the Foundation on improving our philanthropic culture, and our internal way finding plan is being prepared for approval in Q4. Carpet removal is at 88%, slightly below target due to strikes in spring, but expect to be done all removal by March 31, 2014. A reporting on parking opportunities for improvement is also being prepared and expected in the Q4.

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 will take approximately 3 months to complete. Adding in time for Ministry review, it is still possible that we could still have Stage 2 approval before the end of the fiscal year, but it is still a risk it will take beyond March 31, 2014.

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

4. **What new tactics are planned to ensure this milestone is met?**
We are exploring ways to advance our needs with the SE LHIN and MoHLTC Senior Staff to solicit support for advancing our project. As reported in Q2, JPO has also 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 on our own. This may help lesson the impact of delays in Ministry approval Phase 2 Redevelopment. As this approach has costs for the hospital, it will not be undertaken without Board approval.

Kingston General Hospital

MS #10

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

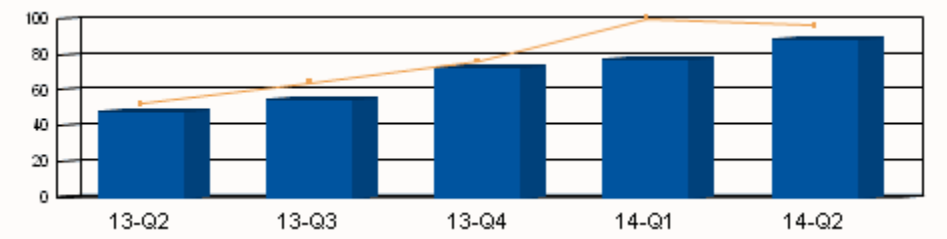
Kingston General Hospital

MS #10

Facilities

Phase 2 redevelopment is advanced

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
13-Q2	48.00	**52**
13-Q3	55.00	**64**
13-Q4	73.00	**76**
14-Q1	76.75	**100**
14-Q2	88.60	**96**

Interpretation - Patient And Business:

Work is slightly behind schedule due to a work stoppage as a result of a labour strike in the summer of 2013. The project's original scope is nearing completion (targetted for the end of January).

Actions & Monitoring Underway to Improve Performance:

The project is under budget and therefore additional flooring replacement work will be completed to maximize the MoHLTC grant. It is estimated that the additional work will be completed by the end of the fiscal year.

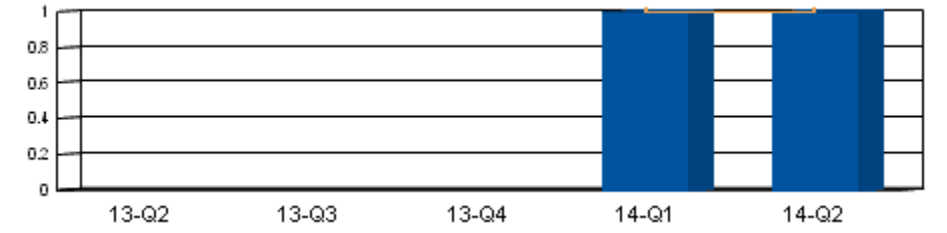
Definition: DATA: Krista Wells-Pearce COMMENTS: Krista Wells-Pearce

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)

Phase 2 redevelopment functional programming commences

Indicator: Stage 2 Approval Status



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

Interpretation - Patient And Business:

A meeting has been scheduled with the SELHIN and HDH on November 6th to discuss the requirements for a citywide OR plan.

Actions & Monitoring Underway to Improve Performance:

The submission of a citywide OR plan will facilitate MoHLTC approval of the KGH Stage One Proposal Submission, and allow us to proceed with Stage Two: Functional Programming.

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 strategic technology projects are overall on time and within budget. See summary below of projects.
2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
   Attention will be focused on any impacts related to recent vacancies in the Project Management Office to ensure projects are well supported. Steering Committees will continue to meet and address any concerns that arise.
3. **Are we on track to meet the milestone by year end?**
   Yes the overall milestones for the projects are still anticipated to be met by year end.
4. **What new tactics are planned to ensure this milestone is met?**
   N/A

EDIS Computerized Provider Order Entry
This project is currently in the planning phase. The EDIS Steering Committee is being renewed and leaders from Lab, DI and Pharmacy will join. Eleanor Rivoire (KGH) and Mike McDonald (HDH) will continue as executive sponsors.

Automated Drug Cabinets
Project is tracking on time and on budget but the quarterly schedule is at risk. Our decision to move to a tender for electrical/data will result in a schedule slip. Fortunately, we will be able to rework the implementation dates so that the project end date is not jeopardized.

Lab Order Entry
Project quarter schedule plan is at risk. Steering committee decided that we should engage the Cancer Centre to review an outpatient workflow to manage complications in processes. This work is in progress and being completed concurrently with the phase 4 portion of the project. Budget is positive.

Staff Scheduling & Time Capture Project
The project is currently working with the vendor in order to complete the design phase. Project team members are completing vendor facilitated product design workshops in order to determine the Kronos solution configuration needed to satisfy identified requirements. At the same time, work is being executed in order to identify the organizational structure needed to support the integration of Payroll, Scheduling and Staffing offices within a new centralized service model.

Regional IT System Progress
Q2 saw SECHEF provide endorsement for the project and the release of the RFP for a consultant to prepare the HIS RFP. In Q3 consult has been selected via RFP to support the preparation and release of an RFP for the Clinical Information Systems for the region.

Kingston General Hospital

MS #11

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	G	G	
		Staff Scheduling and Time Capture Project	N/A	N/A	N/A	G	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	G	G	
		Participation in a Regional Plan for IT Systems	N/A	N/A	N/A	G	G	

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

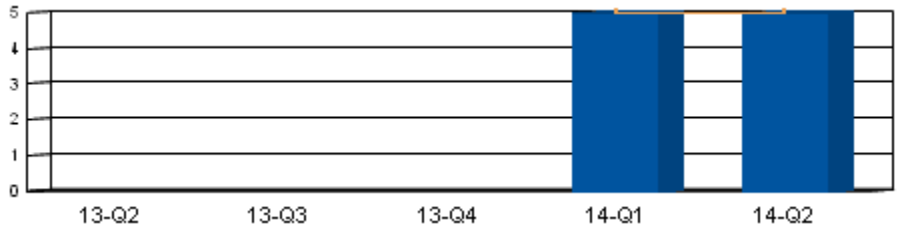
Kingston General Hospital

MS #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-Q2		
13-Q3		
13-Q4		
14-Q1	5	5
14-Q2	5	5

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

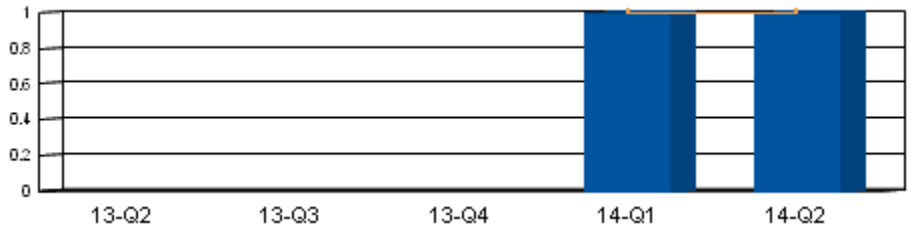
Continue to monitor project delivery via the established steering committees. Attention will be focused on any impacts related to recent vacancies in the Project Management Office.

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

Interpretation - Patient And Business:

Project team engaged in design solution with external vendors. This design solution is needed to determine the next phase of the implementation and deployment approach.

Actions & Monitoring Underway to Improve Performance:

As the product design solution is completed the team will work towards defining the build and test phase. In quarter 3, an enhanced framework to manage this change will be developed along with a deployment strategy.

Definition: COMMENTS: Marion MacInnis

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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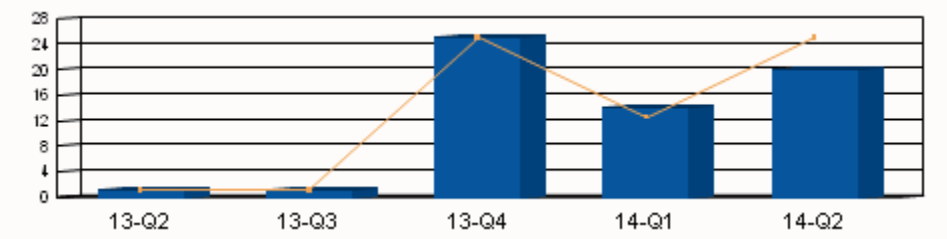
Kingston General Hospital

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-Q2	1	**1**
13-Q3	1	**1**
13-Q4	25	**25**
14-Q1	14	**13**
14-Q2	20	**25**

Interpretation - Patient And Business:

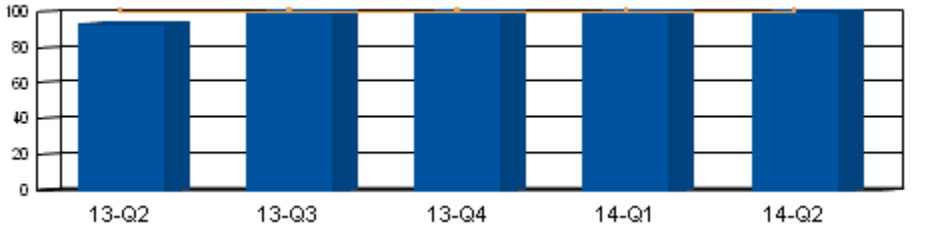
Installs during this Q on C9; C10; PCCU. Planning for installs on K5; C10 and K6 for October / November.
Some delay experienced due to construction / power and data drop installs required. Bundling of these occured to take advantage of cost savings. The implementation schedule has been adjusted so project end date not in jeopardy.

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-Q2	93	**100**
13-Q3	100	**100**
13-Q4	100	**100**
14-Q1	100	**100**
14-Q2	100	**100**

Interpretation - Patient And Business:

Renal is complete. Preparation for implementing the Armstrong clinics is complete but on hold. An opportunity to align outpatient processes lead us to revisit the phlebotomy online entry process in the cancer centre. An improvement cycle is underway which will result in process efficiencies across both cancer centre and Armstrong clinics.

Actions & Monitoring Underway to Improve Performance:

Upon completion of a pilot, scheduled for November, the standardized process will be deployed to outpatient areas simultaneously.

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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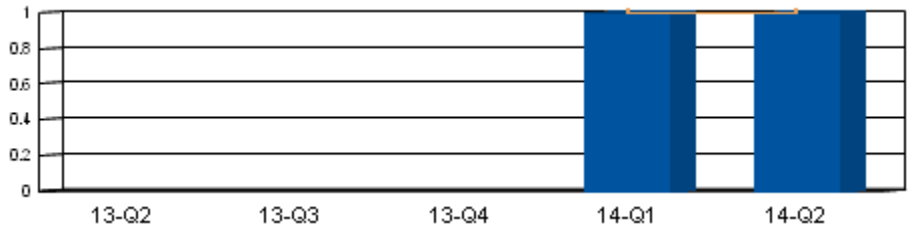
Kingston General Hospital

MS #11

Technology

Strategic technology projects are completed on time and on budget

Indicator: Phase 3 of EDIS is Implemented



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

Interpretation - Patient And Business:

EDIS Phase III Computerized Provider Order Entry is the final phase of the EDIS Project. It is a joint project of KGH and HDH and involves Emergency physicians placing orders for lab, radiology, medications and other orders into the Emergency Department Information System. This phase involves building interfaces to the lab system and to diagnostic imaging to allow these systems to accept the electronic orders. This phase also involves working closely with the Emergency and Urgent Care Centre staff to design electronic processes to replace the current paper driven ordering processes.

EDIS Phase III is currently in the planning phase. The EDIS Steering Committee was expanded to include leaders from Lab, DI and Pharmacy. Eleanor Rivoire (KGH) and Mike McDonald (HDH) will continue as the project's Executive Sponsors. The EDIS Steering Committee will approve the Project Plan and schedule in November.

Actions & Monitoring Underway to Improve Performance:

The biggest risk to this project is the availability and scheduling of resources from Emergency Medicine, Nursing, Information Management, Diagnostic Imaging, Pharmacy and Laboratory to complete the design, build and testing of the electronic processes.

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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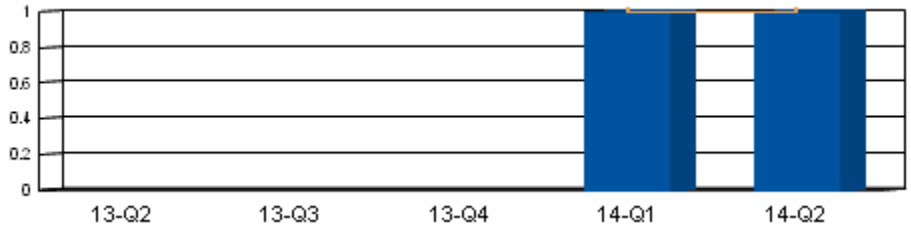
Indicator: Participation in a Regional Plan for IT Systems



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

Interpretation - Patient And Business:

Selection of firm to develop the RFP for a common Hospital Information System (HIS) has closed with final decision pending oral presentations. Successful firm will begin work with the SE LHIN hospitals to define HIS requirements.

Actions & Monitoring Underway to Improve Performance:

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

Green

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 Q2, we had a positive variance to plan of $3 million. While the overall results are positive, we have some ongoing negative pressures, including: lower than anticipated patient revenues, higher compensation related to medicine beds, emergency department, environmental services, and med/surg. supplies. The hospital has seen reduce incidence of code gridlock in the second quarter. The positive results are primarily due to vacancies in several areas of the hospital.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
   Trends seem to be holding in Q3. We are now into preparation of our 2014/15 budget and exploring in detail our financial variances and plans. This activity will help us continue to address the current variances and pressures noted above. Each of the existing variances are being reviewed by Leadership, Finance, and Performance Management teams.

3. **Are we on track to meet the milestone by year end?**
   Yes we are at present projecting a small surplus for the fiscal year.

4. **What new tactics are planned to ensure this milestone is met?**
   No new tactics planned at this time. We anticipate the ongoing quarterly process and portfolio reporting will keep us on track to meet this milestone.

Kingston General Hospital

MS #12

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

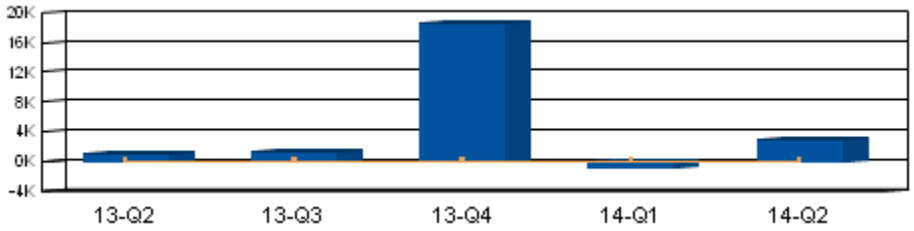
Kingston General Hospital

MS #12

Finances

Financial health is sustained

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



	Actual	Target
13-Q2	941	**0**
13-Q3	1,411	**0**
13-Q4	18,555	**0**
14-Q1	-748	**0**
14-Q2	3,019	**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:

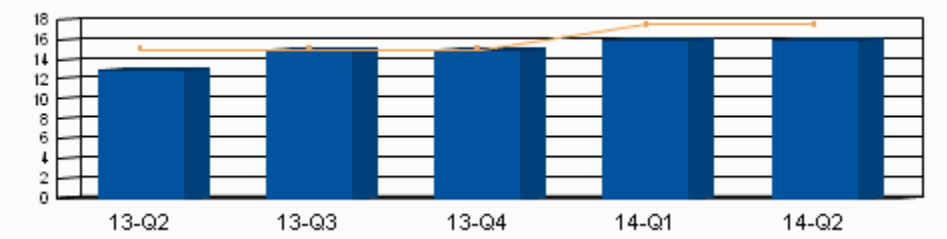
At the end of Q2, the total margin is within the Ministry acceptable range (0 - 3%). The operating results for this period are favourable to budget as reflected in the Hospital Operations Actual vs Plan Variance indicator. At this time, the hospital is projecting an overall balanced operating position setting aside the recognition of prior year deferred funding, working capital deficit funding relief, and amortization expense savings due to anticipated delays in capital expenditure acquisition through the remainder of the 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-Q2	12.9	**15.0**
13-Q3	15.0	**15.0**
13-Q4	15.0	**15.0**
14-Q1	16.0	**17.5**
14-Q2	15.9	**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. Any operating efficiencies identified through the remainder of the fiscal year will be applied to increase this capacity.

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

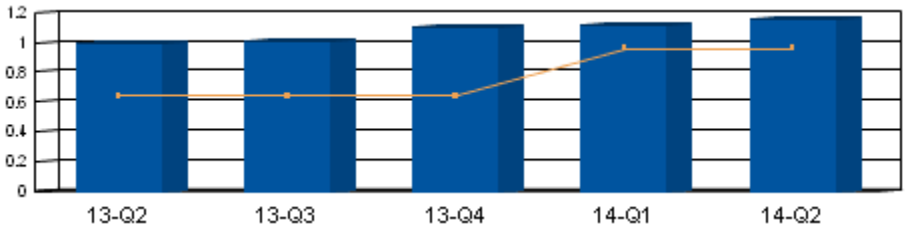
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Current Ratio



	Actual	Target
13-Q2	0.99	**0.64**
13-Q3	1.01	**0.64**
13-Q4	1.10	**0.64**
14-Q1	1.12	**0.96**
14-Q2	1.16	**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 hospital operations current ratio as at the end of Q2 has improved from the prior year ending position due to timing of payroll accrual liabilities, increase in inventory levels, prepaid expenses and amounts owed to the hospital from the LHIN/MOHLTC.

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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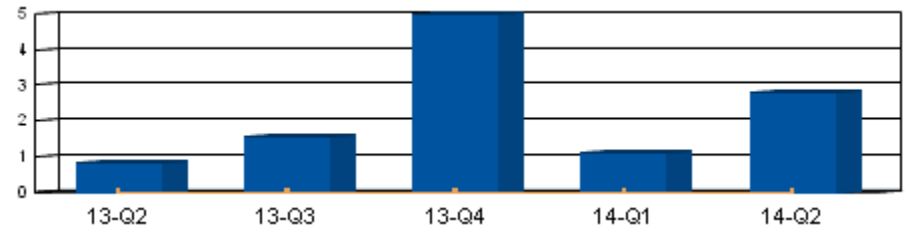
Indicator: Total Margin



	Actual	Target
13-Q2	0.80	**0**
13-Q3	1.55	**0**
13-Q4	4.97	**0**
14-Q1	1.08	**0**
14-Q2	2.78	**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:

At the end of Q2, the total margin is within the Ministry acceptable range (0 - 3%). The operating results for this period are favourable to budget as reflected in the Hospital Operations Actual vs. Plan Variance indicator. At this time, the hospital is projecting an overall balanced operating position setting aside the recognition of prior year deferred funding, working capital deficit funding relief, and amortization expense savings due to anticipated delays in capital expenditure acquisition through the remainder of the year.

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

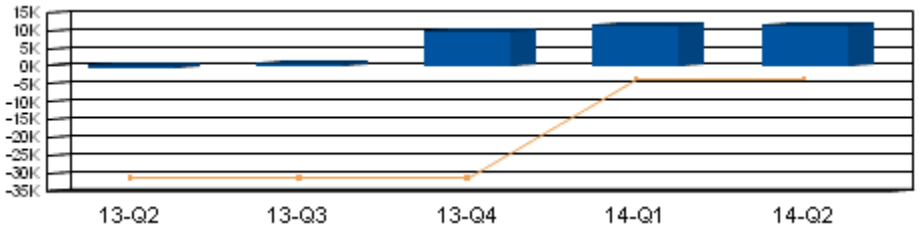
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Working Capital ($000's)



	Actual	Target
13-Q2	-481	**-31500**
13-Q3	610	**-31500**
13-Q4	10,071	**-31500**
14-Q1	11,321	**-3706**
14-Q2	11,312	**-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 operations working capital position as at the end of Q2 has improved from the prior year due to timing of payroll accrual liabilities, increase in inventory levels, prepaid expenses and amounts owed to the hospital from the LHIN/MOHLTC.

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?** A framework and plan for addressing communications training for the KGH Leadership group has been developed, and work builds on the steps taken in Q1 and involve furthering the understanding of what the organization requires of its leaders from a communication perspective; what leaders were expecting by way of communications support; and how equipped leaders felt in meeting expectations; and preparing tools for communication training.

   The KGH 175th Anniversary celebration in September was the culmination of much planning, and was a highlight for KGH and the Kingston Community.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** In Q2 work continued in seeking input from leaders and staff through a more detailed communication audit and with emphasis on leader- manager communication with direct care/service providers. Q2 saw the finalization of the curriculum for the Leadership Communication training sessions which will be launched in Q3.

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?** Communication training sessions are scheduled for Q3 and Q4. Attendance is monitored and preliminary feedback is very positive. In light of the Chief Communications Officer decision to relocate to Toronto, and the reorganization of executive portfolios, recruitment to the newly created Director, Strategy Management and Communications position is critical to sustaining progress with this milestone.

Kingston General Hospital

MS #13

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2
Communication	KGH communication standards are consistently implemented across the organization	Percent of Leaders Who Complete Communication Training	N/A	N/A	N/A	G	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	Y	Y	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

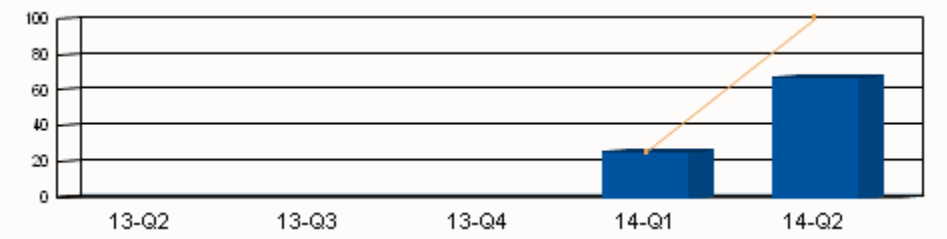
Kingston General Hospital

MS #13

Communication

KGH communication standards are consistently implemented across the organization

Indicator: Percent of Leaders Who Complete Communication Training



	Actual	Target
13-Q2		
13-Q3		
13-Q4		
14-Q1	25	**25**
14-Q2	67	**100**

Interpretation - Patient And Business:

A plan and the framework for how we will address communications training for the KGH leadership group was developed and steps were 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 communications learning and development needs by conducting a 'Think Tank' on high-performance leadership communications in April 2013. In Q2 we continued to seek input from leaders and staff through a more detailed communication audit looking at the overarching communication system in our organization, with emphasis on leader-manager communication with front-line staff. In Q2, we also finalized the curriculum for our Leadership communication training session. The training sessions will take place from October 2013 to January 2014, at which point, all KGH leaders will have completed the training.

Definition: Data: Theresa MacBeth COMMENTS: Theresa MacBeth

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%

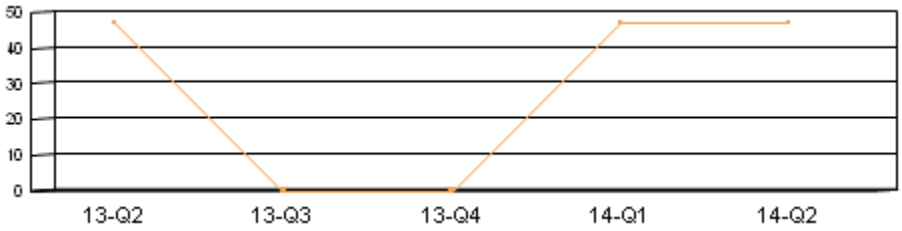
Kingston General Hospital

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-Q2		47
13-Q3		0
13-Q4		0
14-Q1		47
14-Q2		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 yet 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: Theresa MacBeth COMMENTS: Theresa MacBeth

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 Q2 Strategy Report

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	G	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	Y	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	Y	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	G	G	
Cultivate patient oriented research	Externally funded research at KGH has increased to 45%	4% Increase of Externally Funded Research Dollars at KGH	G	G	G	R	Y	↑
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	Y	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	G	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	G	Y	
Processes	Adoption of continuous improvement principles is increased	Number of Improvement Priorities Using PDSA Improvement Cycles	N/A	N/A	N/A	G	G	
Facilities	Phase 2 redevelopment functional programming commences	Stage 2 Approval Status	N/A	N/A	N/A	Y	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	G	G	
Finances	Financial health is sustained	Hospital Operations Actual vs Plan Variance ($000's)	G	G	G	R	G	↑
Communication	KGH communication standards are consistently implemented across the organization	Percent of Leaders Who Complete Communication Training	N/A	N/A	N/A	G	G	

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

Kingston General Hospital

2014 QIP

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2	
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	N/A	N/A	↑
		Overall Emergency Care Patient Satisfaction (%) - (QIP)	G	G	G	N/A	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	Y	Y	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	R	R	R	R	G	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days - (QIP)	G	Y	G	Y	Y	↑
		Hand Hygiene Compliance - (QIP)	Y	G	Y	Y	R	↓
		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	Y	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	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	Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile - (QIP)	Y	G	G	R	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
Q2 F2014

			13-Q2	13-Q3	13-Q4	14-Q1	14-Q2
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	Y	R	R
		OHS - Management Inspection Program	R	R	G	G	R
		OHS - Respirator Fit Testing & Training Compliance	R	Y	Y	R	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	G	G	G	G
		OHS - Incident Investigations Complete	R	R	R	Y	R
		OHS - Lost Time Severity Rate (Days Lost/100 Workers)	G	G	G	Y	R
		OHS - Needlestick Injuries (NSI's) Only	R	R	R	G	R
		OHS - Total MSI Incidents	R	R	Y	Y	Y
		OHS - MSI Lost Time Injury Claims (LTIs)	G	G	G	G	G
		OHS - MOL Reported Critical Injury Incident	G	G	G	G	Y
		OHS - WSIB Lost Time Claims	G	G	G	G	G

115	13-Q2	13-Q3	13-Q4	14-Q1	14-Q2
OHS - WSIB Health Care Claims	R	R	R	Y	Y
OHS - Occupational Illness Reported to MOL	G	G	Y	G	G
OHS - MOL Orders Issued During Site Visit	G	R	G	G	G
OHS - Mandatory Safety Training (Overall Compliance)	Y	Y	Y	Y	R
OHS - Pre-Placement Health Screening Completed	G	G	G	G	Y

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

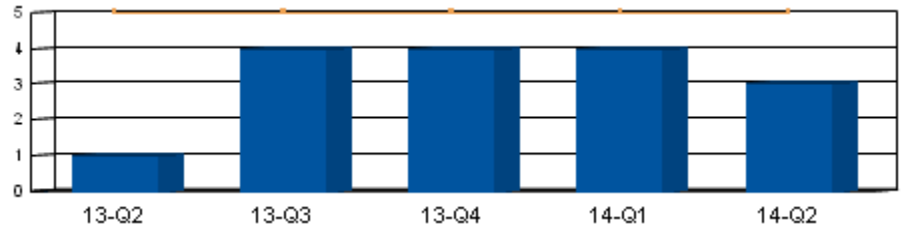
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB Lost Time Claims



	Actual	Target
13-Q2	1	<5
13-Q3	4	<5
13-Q4	4	<5
14-Q1	4	<5
14-Q2	3	<5

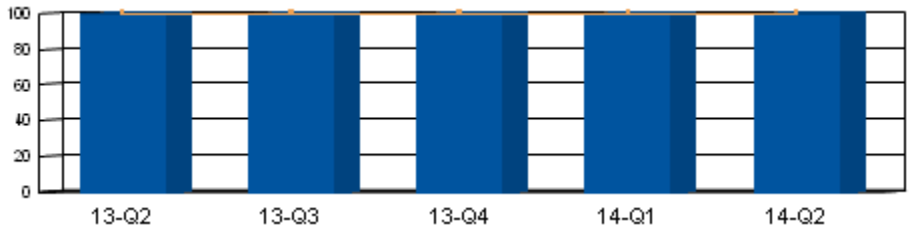
Interpretation - Patient And Business:

All 3 lost time claims were the results of Falls; 2 were falls on stairs and other was a fall from a stool. Total days lost related to these 3 claims was 11.

Definition:

Target: Target 2013/14:

Indicator: OHS - JHSC Health & Safety Inspections Completed

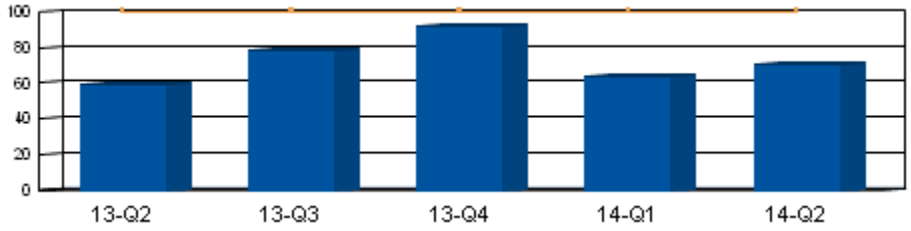


	Actual	Target
13-Q2	100	100
13-Q3	100	100
13-Q4	100	100
14-Q1	100	100
14-Q2	100	100

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

Target: Target 2012/13: 100%, Target 2013/14: 100%

Indicator: OHS - 21 Day Response to JHSC Identified Hazards



	Actual	Target
13-Q2	59	100
13-Q3	78	100
13-Q4	92	100
14-Q1	64	100
14-Q2	71	100

Interpretation - Patient And Business:

Some improvement over Q1. Electronic forms now in place for improved ease of use.

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%

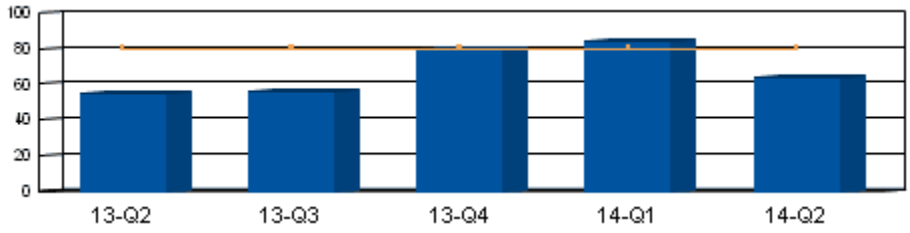
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Management Inspection Program

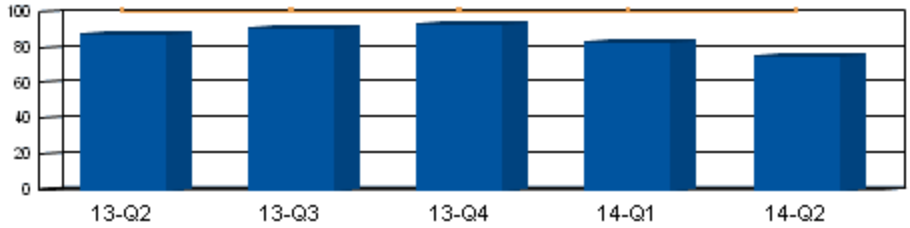


	Actual	Target
13-Q2	55	80
13-Q3	56	80
13-Q4	80	80
14-Q1	84	80
14-Q2	64	80

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-Q2	87	100
13-Q3	91	100
13-Q4	93	100
14-Q1	83	100
14-Q2	75	100

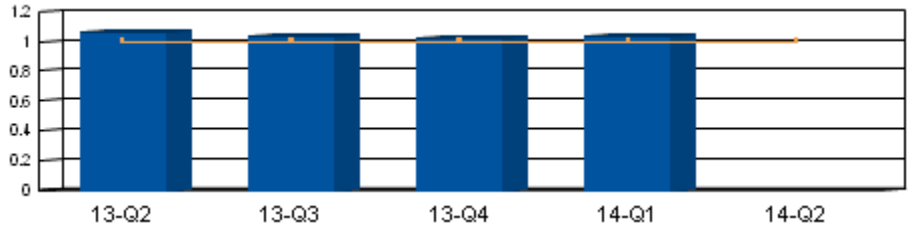
Interpretation - Patient And Business:

Schedule currently in place to achieve compliance by mid November.

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-Q2	1.06	≤1
13-Q3	1.04	≤1
13-Q4	1.02	≤1
14-Q1	1.03	≤1
14-Q2		≤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

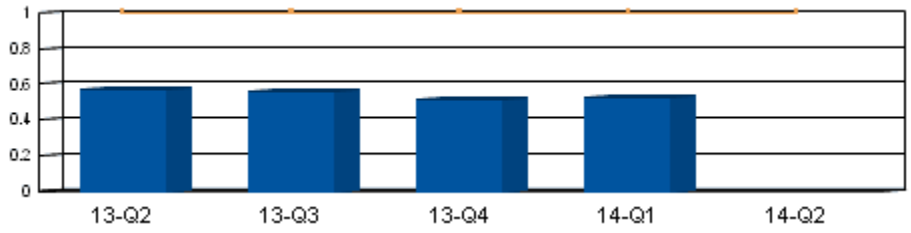
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2010

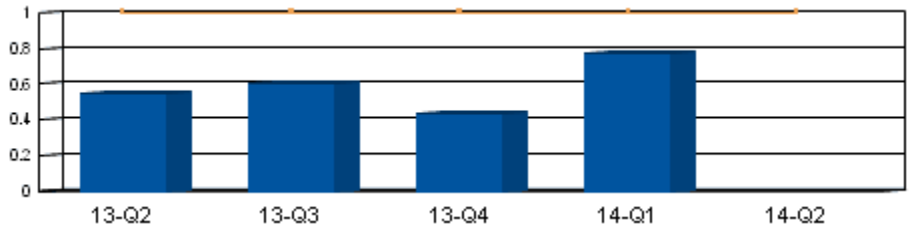


	Actual	Target
13-Q2	0.57	≤1
13-Q3	0.56	≤1
13-Q4	0.51	≤1
14-Q1	0.52	≤1
14-Q2		≤1

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

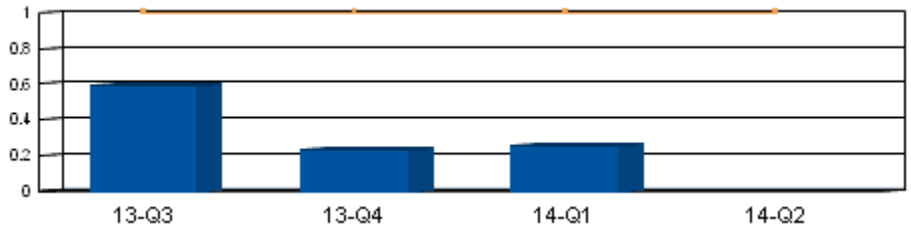


	Actual	Target
13-Q2	0.55	≤1
13-Q3	0.60	≤1
13-Q4	0.44	≤1
14-Q1	0.77	≤1
14-Q2		≤1

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
13-Q4	0.23	≤1
14-Q1	0.26	≤1
14-Q2		≤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

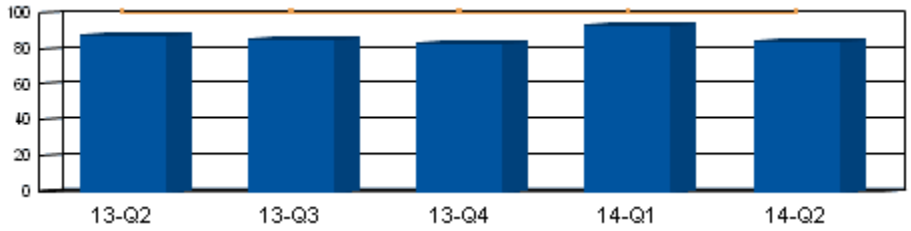
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Incident Investigations Complete



	Actual	Target
13-Q2	87	**100**
13-Q3	85	**100**
13-Q4	83	**100**
14-Q1	93	**100**
14-Q2	84	**100**

Interpretation - Patient And Business:

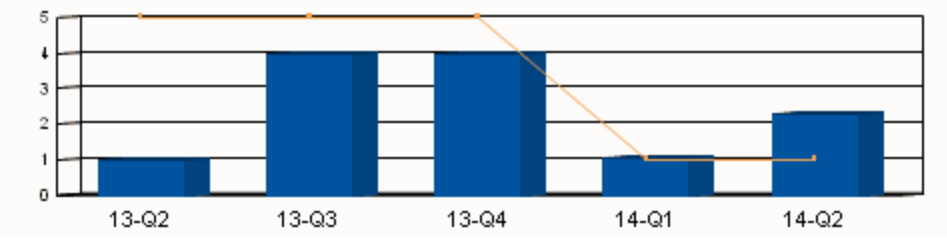
Completion rates were as follows:

July- 91%
Aug- 84%
Sept- 77%

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-Q2		
13-Q3		
13-Q4		
14-Q1	1.0	**≤1**
14-Q2	2.3	**≤1**

Interpretation - Patient And Business:

Number of days lost due to workplace injury was more than double that of Q1. This is mainly related to an earlier WSIB injury claim that was reactivated resulting in 66 days lost in Q2.

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

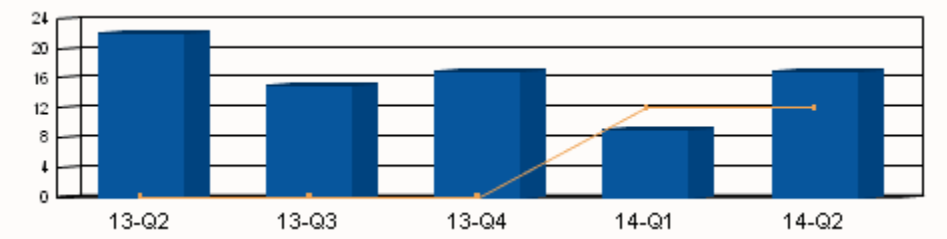
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

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



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

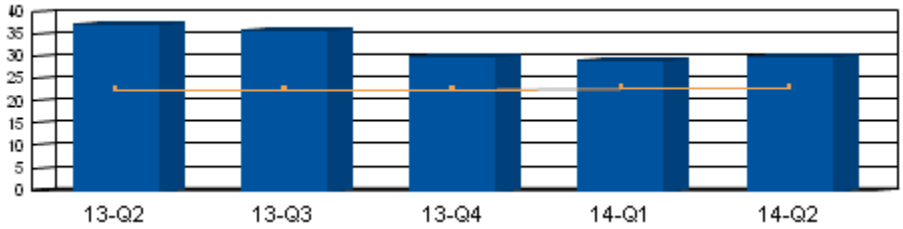
Interpretation - Patient And Business:

Nearly 1/4 of NSIs occurred during subcutaneous injection. Needle Safety tactic underway- currenlty working with units to identify factors contributing to NSIs in their areas.

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

Indicator: OHS - Total MSI Incidents



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

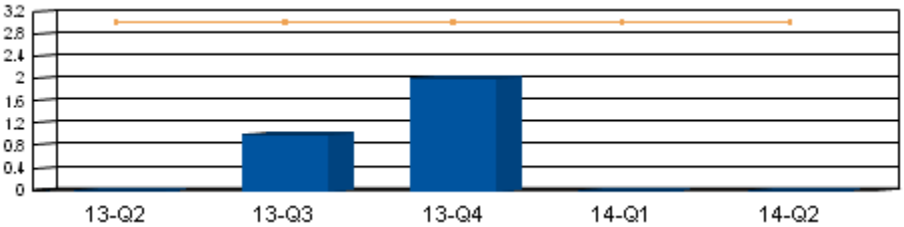
Interpretation - Patient And Business:

About half of MSIs occur during patient handling activities. MSI prevention tactic underway.
Top Depts for MSIs- Medicine (8), SPA (6), Environmental Services (5), Critical Care (5).

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

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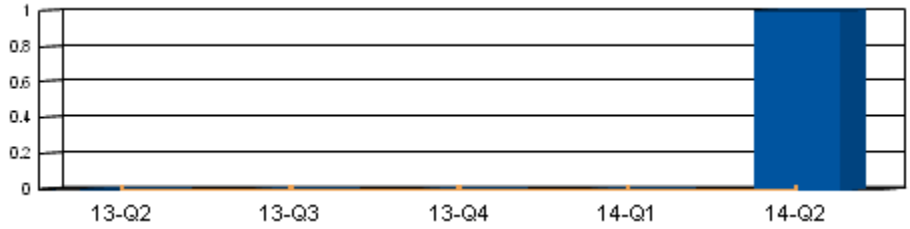
Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - MOL Reported Critical Injury Incident



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

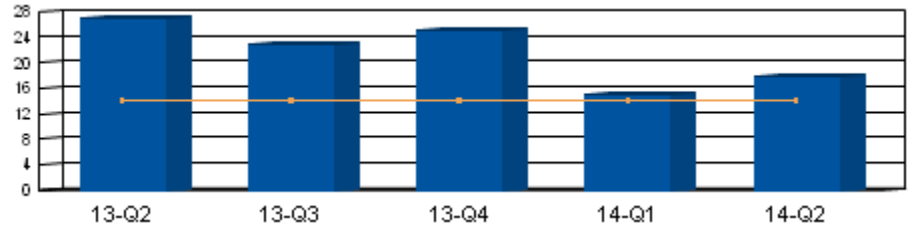
Interpretation - Patient And Business:

Fall which resulted in unconsciousness

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

Indicator: OHS - WSIB Health Care Claims



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

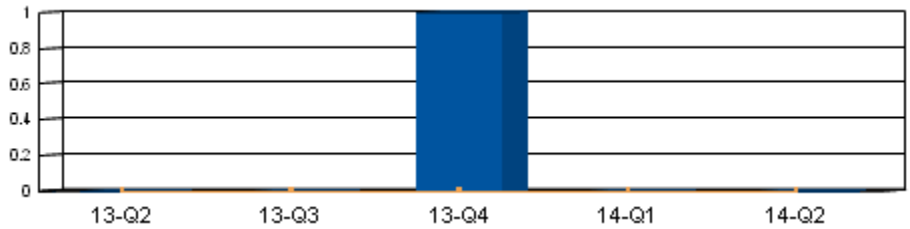
Interpretation - Patient And Business:

28% occurred in Critical Care and 22 % in Medicine. Top two Injury classications resulting in healthcare claims were MSIs due to patient handling (28%) and NSI's (17%).

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-Q2	0	**0**
13-Q3	0	**0**
13-Q4	1	**0**
14-Q1	0	**0**
14-Q2	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:

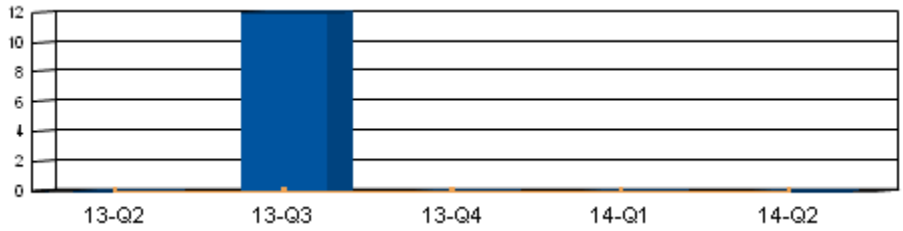
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - MOL Orders Issued During Site Visit



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

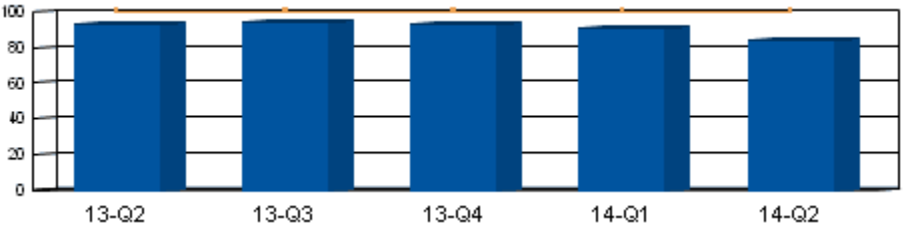
Interpretation - Patient And Business:

No MOL visits this quarter

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

Indicator: OHS - Mandatory Safety Training (Overall Compliance)



	Actual	Target
13-Q2	93	**100**
13-Q3	94	**100**
13-Q4	93	**100**
14-Q1	91	**100**
14-Q2	84	**100**

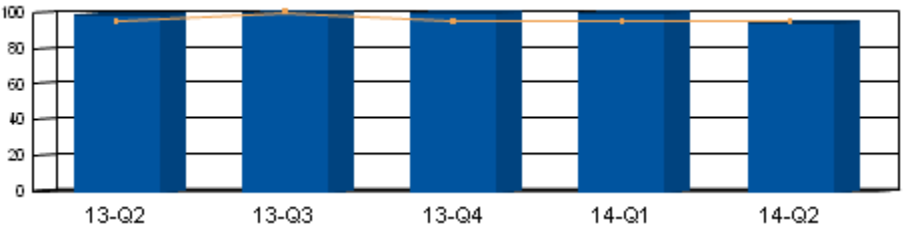
Interpretation - Patient And Business:

New addition in Q2 of a Quarterly Safety Talk as a component of mandatory safety training. Q2 Safety Talks completion at 54%.

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-Q2	99	**95**
13-Q3	100	**95**
13-Q4	100	**95**
14-Q1	100	**95**
14-Q2	94	**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%