fiscal 2013-2014 **Q3**

3rd quarter ended December 31, 2013

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

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Master Performance Report
Q3 Fiscal 2013 - 2014

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

Green

Strategic Direction	KGH 2015 outcome	Indicator
Transform the patient experience through a relentless focus on quality, safety and service	**Patients are engaged in all aspects of our quality, safety and service improvement initiatives**	**Percent improvement priorities with Patient Experience Advisors engaged**

Improvement Priorities
Expand the scope of the Patient Experience Advisor Program

1. **What is our actual performance on the indicator for this milestone as listed above?** The process to support patient experience advisors being engaged and prepared to participate as equal members of improvement teams is established and in use. The process involves recruiting, educating and aligning interests of advisors to PDSA cycles, and supporting leaders with integrating advisors as team members. Currently 12 advisors have received the same CI education as provided to all staff, and these advisors are involved on 16 of the 17 existing PDSA teams.

   That said, while the supporting metric of overall satisfaction with care received at KGH is meeting the threshold, the recently received Q1 and Q2 NRC Picker satisfaction results are concerning in that there is a downward trend in all 8 dimensions of patient satisfaction. This trend needs to be closely monitored and steps taken to reverse the trend. As well , the specific indicator of satisfaction with food is not yet showing anticipated levels.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Continued recruitment and education of advisors; consultation with improvement teams to determine if the work will have material impact on patient experience, and if so to align an advisor to the team. The interest of other organizations in learning the KGH processes for partnering with patients in co-design, and the profile of this work nationally helps to reinforce this innovation and the pride of those involved.

3. **Are we on track to meet the milestone by year end?** The strategic milestone is on track and is expected to be met by year end. There is need for oversight of supporting indicators with patient satisfaction, and ongoing work with improvement initiatives to achieve and sustain desired targets.

4. **What new tactics are planned to ensure this milestone is met?** Engagement of advisors will continue to be supported. The NRC Picker results will be presented at leadership and professional forums, and will be shared with all programs and services (i.e. Nutrition Services) with request to advance work underway and/or consider additional tactics that can/ought to be taken to improve patient satisfaction.

Kingston General Hospital

MS #01

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

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

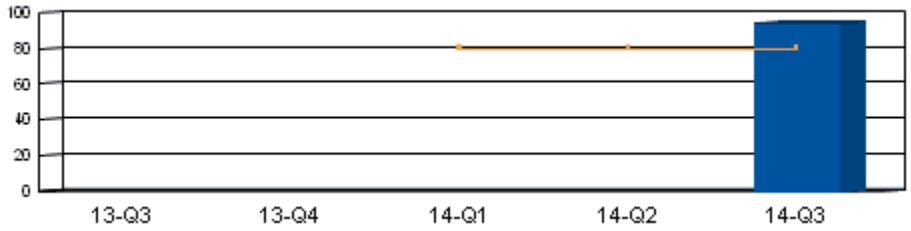
Kingston General Hospital

MS #01

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

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

Indicator: Percent Improvement Priorities with Patient Experience Advisors Engaged



	Actual	Target
13-Q3		
13-Q4		
14-Q1		80
14-Q2		80
14-Q3	94	80

Interpretation - Patient And Business:

Patient Experience Advisors have and continue to be recruited to participate on improvement processes. Each receives the same education program as provided to all leaders and participants of improvement teams. The advisors have been preferentially included in initiatives aligned to the Gridlock and the patient safety initiatives reporting to the QPCC. To date, 12 advisors have completed the education and, as a result, 16 of 17 improvement teams now include advisors, and work is underway to align an advisor to the team working on infection control issues. In addition, one advisor was part of the overall Gridlock VSM process prior to the education programming being made available. Advisors are not becoming engaged on teams where the work does not have a material impact on patient experience (i.e. electronic on call system which is part of the Gridlock VSM).

Actions & Monitoring Underway to Improve Performance:

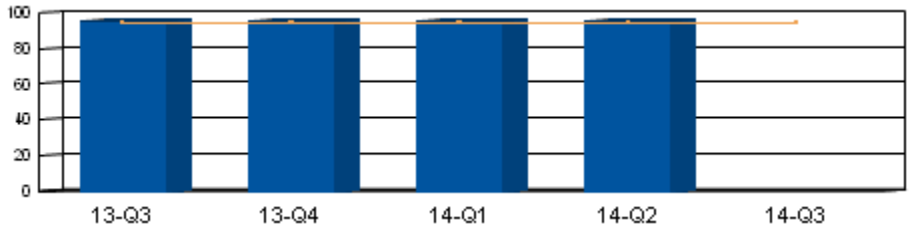
Continue to support education of advisors as it enables them to be equal partners in the CI/VSM processes; recruit advisors to be available to consider and become engaged in project work; support the process to catalogue their work and involvement; celebrate the involvement in the accomplishments of the teams through education events linked to patient safety week/KGH Community Showcase 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: DATA: Eleanor Rivoire COMMENTS: Eleanor Rivoire STRATEGY INDICATOR

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-Q3	95	94
13-Q4	95	94
14-Q1	95	94
14-Q2	95	94
14-Q3		94

Interpretation - Patient And Business:

Results reflect survey data from 2013 Jul-Sep.
Scores reflects combined survey responses for good, very good and excellent. ON Teaching Hospitals average for the same time period in 93.5%

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong SUPPORTING INDICATOR

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%

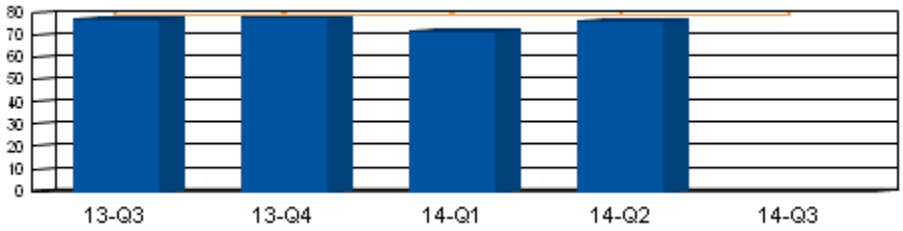
Kingston General Hospital

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-Q3	77	**79**
13-Q4	78	**79**
14-Q1	72	**79**
14-Q2	76	**79**
14-Q3		**79**

Interpretation - Patient And Business:

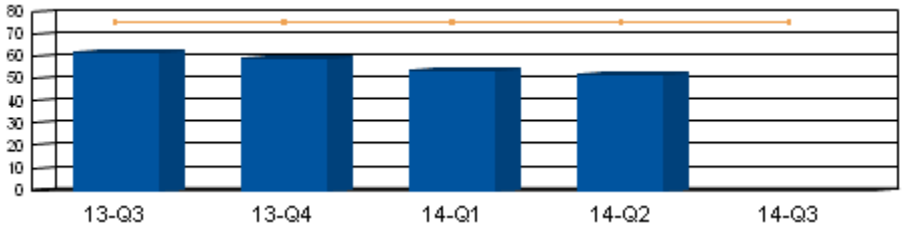
Comment reflects Jul-Sep survey results. We are approaching our ON Teaching Hospitals benchmark. We continue to use this retrospective patient satisfaction indicator in combination with our more current patient relations feedback and patient feedback forums to inform patient experience improvement opportunities.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong SUPPORTING INDICATOR

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-Q3	62	**75**
13-Q4	59	**75**
14-Q1	54	**75**
14-Q2	52	**75**
14-Q3		**75**

Interpretation - Patient And Business:

The overall patient satisfaction score from the Compass survey for Q2 reporting was 96%. The target for fiscal 2014 is 78% at the enthusiastic level (i.e. excellent/very good). The corresponding score for Q2 was 66%; a 10% increase from Q1. No survey was undertaken in Q3. The next survey will be reported in the Q4 timeframe.
The information provided by the NRCC survey for Q2 indicates a slight decline from Q1; a trend similar to the Compass survey for overall patient satisfaction (i.e. 97% Q1 to 96% Q2).

Actions & Monitoring Underway to Improve Performance:

It is anticipated that the actions undertaken to address areas of concern in the Q2 survey will result in higher patient satisfaction scores in the Q4 survey.

Definition: DATA: Astrid Strong COMMENTS: J'Neene Coghlan SUPPORTING INDICATOR

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%

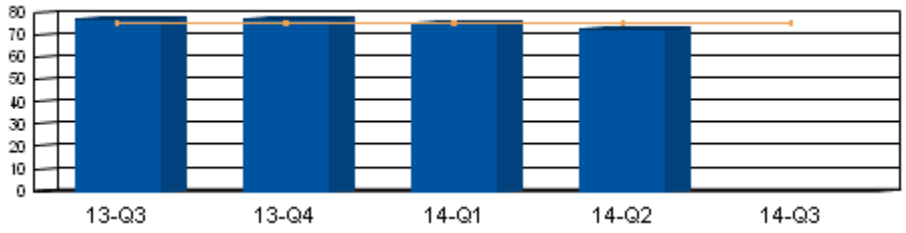
Kingston General Hospital

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-Q3	77	**75**
13-Q4	77	**75**
14-Q1	75	**75**
14-Q2	73	**75**
14-Q3		**75**

Interpretation - Patient And Business:

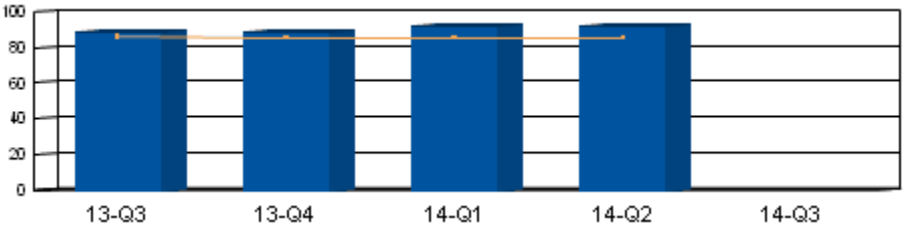
Comment reflects result data from Jul-Sep.
Percent score combines the percent positive score for the 8 dimensions of care that includes access to care, emotional support, information& education, physical comfort, involvement of family, respect for patient preferences, continuity & transition and coordination of care. ON Teaching Hospital average for the same period is 75%.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong QIP INDICATOR

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

Interpretation - Patient And Business:

Data for Q3 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 QIP INDICATOR

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

Red

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?**

Of the 4 primary improvement priorities, 3 are red and one green (new HAI). CDI rates have continually decreased over the last 4 months and 3 quarters. Linked with this would appear to be a second drop in antibiotics dispensed Q1 to Q3, also now better than target. The MRSA, CLI, VRE, VAP are very low incidents but with a small denominator. Specimen collection errors and medication fluid event PDSA tactics have not shown any Q3 data and will need to be revisited. Level 3 and 4 falls have increased over Q2. Critical Incident Reviews have identified consistent concerns that are being address by the Fall Prevention Committee and ICPM Records.

There are 23 indicators in the MS: 8G, 7Y, R6 and 2 not reporting. G+Y = 71% of reporting indicators. Two indicators deserve attention:

1. Hand Hygiene – rates continue to decrease over the last 5 quarters. IPC has initiated a blitz on signage and education. Auditing issues in the first 2 quarters has been rectified and now are considered valid.
2. VRE – as one of the 'Fab 4' hospitals not screening for VRE, we have not seen a rise in infection rates. Formal reporting from the combined Infection Prevention team is pending this spring.

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)

- IPC team is aggressively targeting the HH compliance rates – frequent auditing; replacing postings on units and entrances; educational support at unit level
- Falls Prevention Committee is reviewing efficacy of current initiatives in light of CIR
- Specimen Collection Errors - needs a relook at engagement/process
- Medication Fluid Events – Auto drug cabinet installation stalled; need to refresh PDSA

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

Of the primary indicators yellow status likely with significant attention to Falls and completion of tactics for the specimen and medication errors.

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

IPC team addressing HH compliance.

Kingston General Hospital

MS #02

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

14	13-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
External Environmental Audits by Westech	N/A	Y	Y	Y	Y	↑
Hand Hygiene Compliance - (QIP)	G	Y	Y	R	R	↓
Hospital Standardized Mortality Ratio (HSMR)	R	G	N/A	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	N/A	N/A	N/A	N/A	
Percent of Patients Responding "Satisfied" to the KGH Environmental Patient Discharge Survey	Y	G	G	Y	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	G	G	G	↑

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

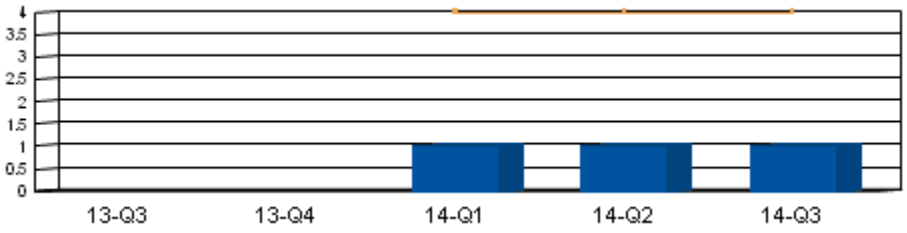
Kingston General Hospital

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

Interpretation - Patient And Business:

Of the four rolled up indicators, only a reduction in new hospital acquired infections achieved target (green). The remainder is all red. Specimen collection errors and medication fluid events each have three indicators embedded that have shown progress in tactic development and receive yellow status. Falls is red and has raised Patient Safety and Quality Committee's awareness and accountability to the Falls Committee for urgent attention.

Actions & Monitoring Underway to Improve Performance:

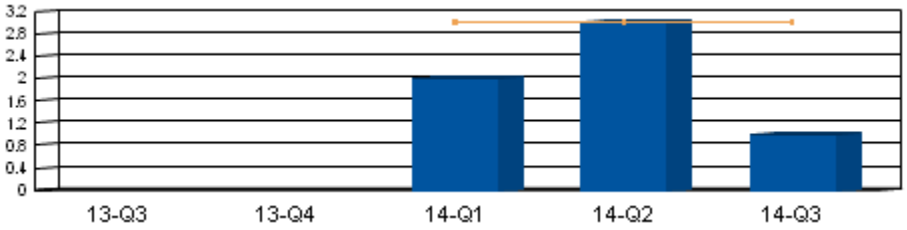
The incidence in L3 and L4 Falls is need of a review of current falls prevention management and risk management. The Falls Committee will be addressing. Specimen and Medication errors tactics need a re-look at barriers that have slowed progress.

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

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

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

Indicator: Reduce the top 3 errors associated with specimen collection



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

Interpretation - Patient And Business:

Leaky urine update: Q3 report: Progress made in Quarter 2 holding and seeing continued positive trending. Will continue to monitor over next several quarters. A more involved PDSA is currently underway to ensure all areas have been included. Phase 1 scheduled to start November 2013.

Deviation from standard operating procedure (Glucose connectivity). Q3 update: Meetings involving Nursing Practice Council and with Clinical Educators have started. POCT to provide data. Limited progress made in this area due to extended staff sickness, data was not able to be pulled, inconsistencies in data reporting is causing a relook at the data to ensure that the data is valid and reflective of issue.
ID specimen mismatch/unlabeled; Q3 update: standard work now in place in ED, FAPC and Cancer centre, final team being hired. Preliminary work has identified the 2 IP units where the phlebotomy team will start from. Work continues in this area but at a very slow pace.

Definition: COMMENTS: Joyce deVette-McPhail SUPPORTING INDICATOR

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

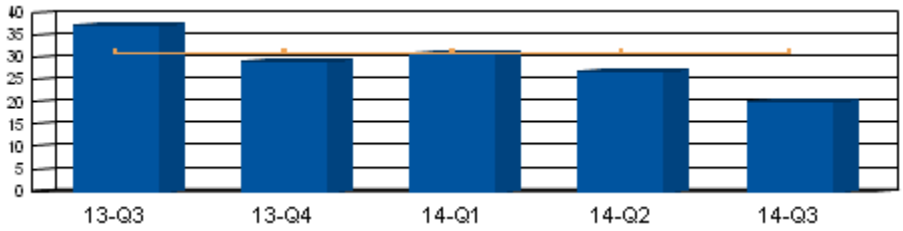
Kingston General Hospital

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-Q3	37	**31**
13-Q4	29	**31**
14-Q1	31	**31**
14-Q2	27	**31**
14-Q3	20	**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. In Quarter 3, we had 5 MRSA bacteremias, 2 VRE bacteremias and 13 cases of CDI which is 7 fewer infections than Quarter 2.

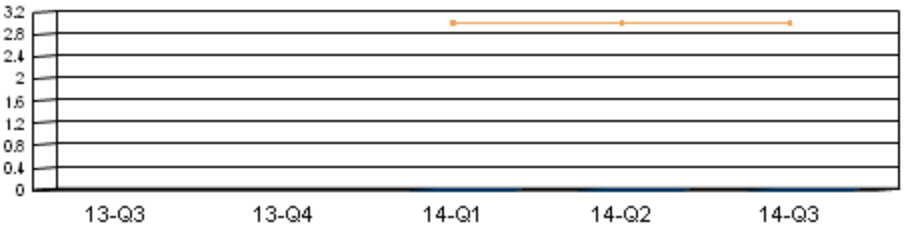
Business Perspective: The target reduction has been achieved principally due to a decrease in CDI infections over the last 19 months. .

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

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

Interpretation - Patient And Business:

Automated Dispensing Cabinets: 50% completion as of December 2013. Audit of impact on hydromorphone/morphine errors planned for March 2014. OPIS 2005 adult inpatient chemotherapy: Planned implementation date: February 24, 2014.

Actions & Monitoring Underway to Improve Performance:

Implementation of dispensing cabinets has seen a construction delay that will prevent project completion until late Q4 or Q1 next fiscal. Similarly the OPIS implementation is just beginning. Q4 may provide impact results. Given the delay in process, further medication errors will be addressed.

Definition: COMMENTS: Veronique Briggs SUPPORTING INDICATOR

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

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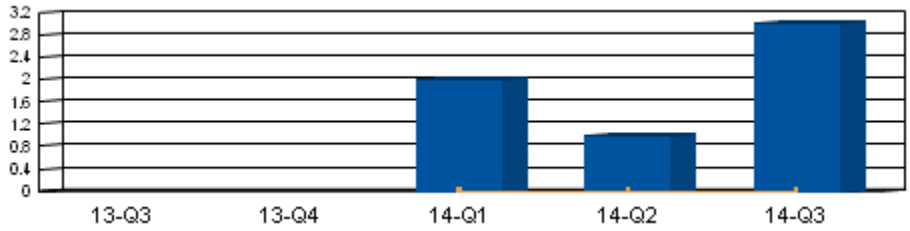
Transform the patient experience through a relentless focus on quality, safety and service

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

Interpretation - Patient And Business:

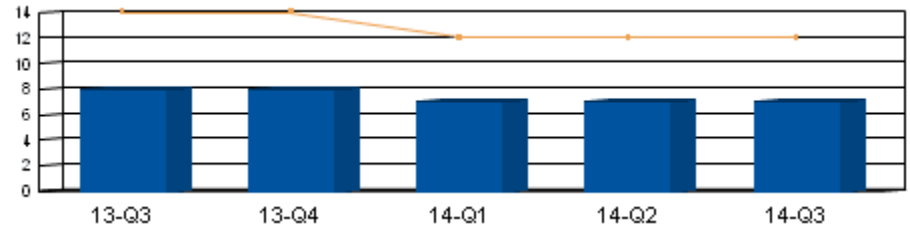
For Q3, two moderate patient harm severity level 3 falls & one critical patient harm level 4 fall occurred.
A corporate Quality of Care Review for the critical level 4 fall resulted in a number of recommendations currently being implemented.
Program level quality of care reviews for level 3 falls did/will occur to identify root cause & recommendations to be shared with the program staff.
The Falls Tactic team continues to work on improvement opportunities focused on strategies for ongoing patient communication, physical environment safety checks and staff education.

Definition: DATA: Richard Jewitt COMMENTS: Richard Jewitt QIP INDICATOR

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

Interpretation - Patient And Business:

Performance is unchanged from last quarter with 7/12 indicators green or yellow. Changes from Q2 are a drop below target in antibiotics dispensed (green) and Falls converting yellow to red.

Actions & Monitoring Underway to Improve Performance:

Hand hygiene, falls and e-discharges will need review of current activities supporting them and reassess sustainability of previously successful initiatives.

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

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

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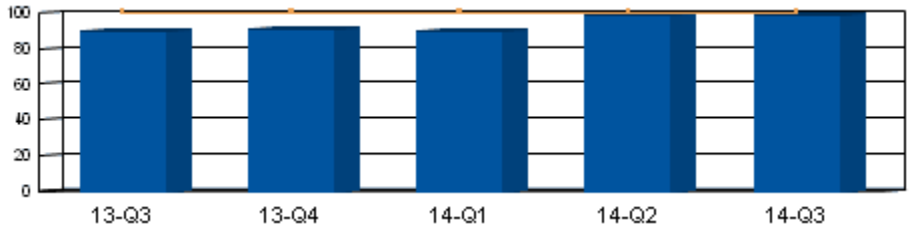
Transform the patient experience through a relentless focus on quality, safety and service

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

Interpretation - Patient And Business:

Overall the compliance for all surgical services to complete the 3 phases of the surgical safety checklist for all operative activity (urgent, elective) for Q3 (2,335 cases) is the following: Briefing - 99.6%, Timeout- 99.4% and the final Debrief - 99.6%.

Actions & Monitoring Underway to Improve Performance:

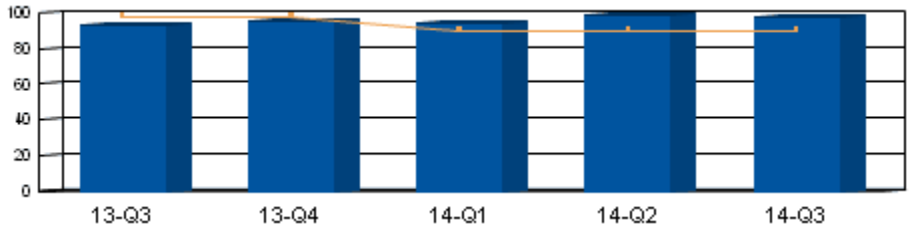
Focus on urgent/emergent activity SSCL reporting continues in order to meet the overall average target of 100%.

Definition: DATA: Kathleen Wattie Barnett COMMENTS: Kellie Kitchen QIP INDICATOR

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

Interpretation - Patient And Business:

Patient Perspective: We continue to be able to achieve the target for the appropriate timing of prophylactic antibiotic administration, for primary hip and knee replacements, which reduces the risk for patients of postoperative infections.

Business Perspective: Real time electronic documentation of the OR record was implemented in Quarter 1 and as a result of this change to the documentation process our compliance has remained well above the target.

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

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

Target: Target 09/10: 91.95%, Target 10/11: Provincial Teaching Avg. Or Better, Target 11/12: Provincial Avg. Or Better Target 13/14: PAOB Perf. Corridor: Red <10% Prov. Rate Yellow Within 10% Prov. Rate Green >= Prov. Rate

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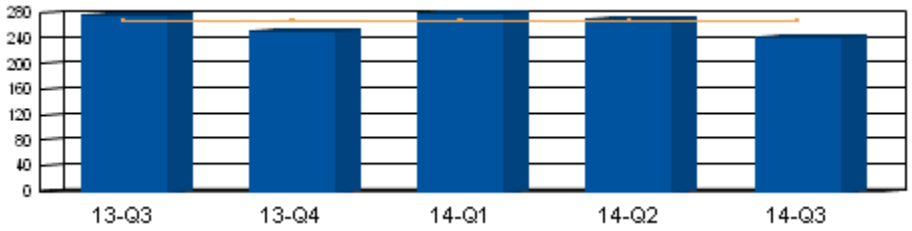
Transform the patient experience through a relentless focus on quality, safety and service

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-Q3	275	**267**
13-Q4	252	**267**
14-Q1	278	**267**
14-Q2	271	**267**
14-Q3	243	**267**

Interpretation - Patient And Business:

This indicator has now consistently trended down over the last 2 quarters and is now below the target (green). This reflects the beneficial effects of the antibiotic stewardship program implement and coincides with significant decrease in the C difficile rate.

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

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%

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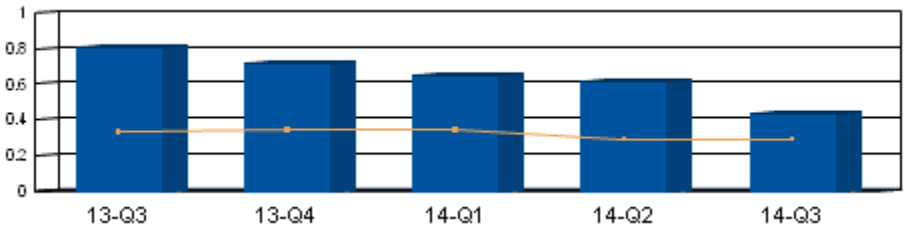
The top sources of preventable harm to patients are addressed

Indicator: C-Difficile (Reported Monthly)



	Actual	Target
13-Q3	0.81	**0.33**
13-Q4	0.72	**0.34**
14-Q1	0.65	**0.34**
14-Q2	0.62	**0.29**
14-Q3	0.44	**0.29**

Interpretation - Patient And Business:

Patient Perspective: The last 5 quarters monthly values were: August - 3 cases; September - 11 cases (4 cases were identified on one unit within a 4 week period); October - 8 cases; November - 4 cases and December - 1case.

Business Perspective: 19 months with no CDI outbreaks facility wide or unit specific.

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

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

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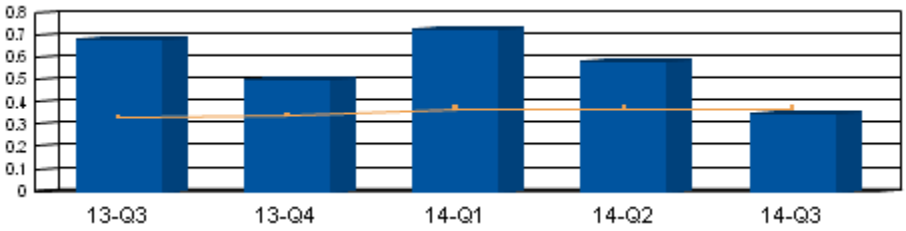
Indicator: C-Difficile (Reported Quarterly)



	Actual	Target
13-Q3	0.68	**0.33**
13-Q4	0.50	**0.34**
14-Q1	0.73	**0.37**
14-Q2	0.58	**0.37**
14-Q3	0.35	**0.37**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.35 cases per 1000 patient days; a decrease from the first quarter of 2013- 2014. In October we had 8 cases of CDI. In November we had 4 cases and in December there was only 1 case giving us a total of 13 cases for this quarter; in comparison to Quarter 1, where we had 27 cases and Quarter 2 where we had 21cases.

Business Perspective: It is worth noting that we also had identified 10 cases of community/other facility acquired CDI on admission to KGH.

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

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 >0.42 Yellow 0.38-0.41 Green <=0.37

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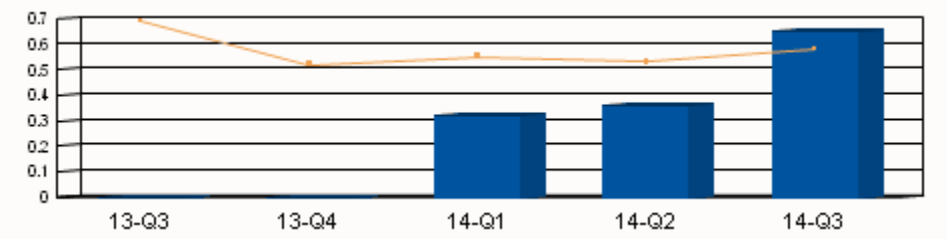
The top sources of preventable harm to patients are addressed

Indicator: Central Line Bloodstream Infections



	Actual	Target
13-Q3	0.00	**0.69**
13-Q4	0.00	**0.52**
14-Q1	0.32	**0.55**
14-Q2	0.36	**0.53**
14-Q3	0.65	**0.58**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

Continue to monitor 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: Julie Caffin SUPPORTING INDICATOR

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

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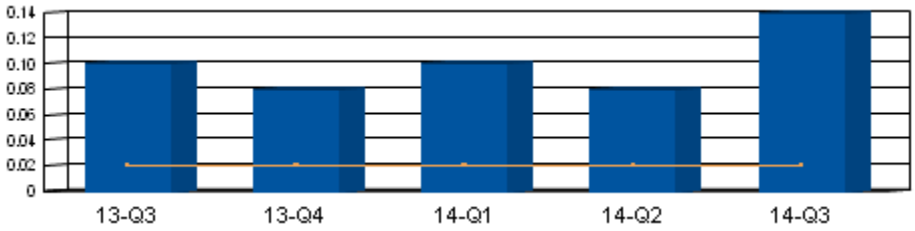
The top sources of preventable harm to patients are addressed

Indicator: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
13-Q3	0.1	**0.02**
13-Q4	0.1	**0.02**
14-Q1	0.1	**0.02**
14-Q2	0.1	**0.02**
14-Q3	0.1	**0.02**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.14 per 1000 patient days which represents 5 cases. This is an increase from Quarter 2 when we had 3 cases and a rate of 0.08. We had experienced 1 case in October and 2 cases in both November and December. All cases were newly positive for MRSA.

Business Perspective: IPAC Service is working with each Program to identify opportunities to improve their compliance with the MRSA Admission Screening Medical Directive. Our recent monthly compliance rates have averaged below 50%. This means potentially we are missing identifying patients when they are admitted as colonized/infected and as a result must call them nosocomial to KGH when they may have been positive from either the community or another facility.

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

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

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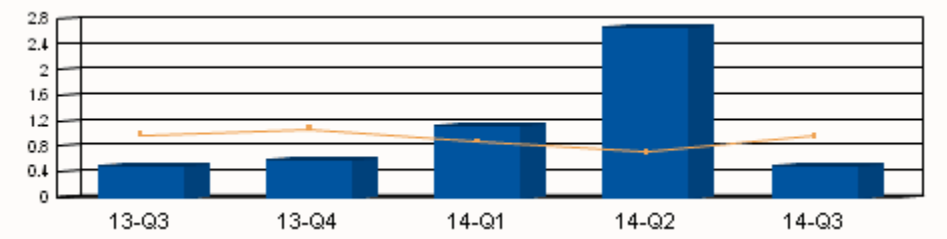
Indicator: Ventilator Associated Pneumonia



	Actual	Target
13-Q3	0.50	**0.97**
13-Q4	0.60	**1.07**
14-Q1	1.13	**0.87**
14-Q2	2.66	**0.70**
14-Q3	0.48	**0.95**

Interpretation - Patient And Business:

A rate of 0.48 is reflective of one case of VAP.

Actions & Monitoring Underway to Improve Performance:

Continued monitoring and auditing

Definition: DATA: CCIS COMMENTS: Julie Caffin SUPPORTING INDICATOR

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

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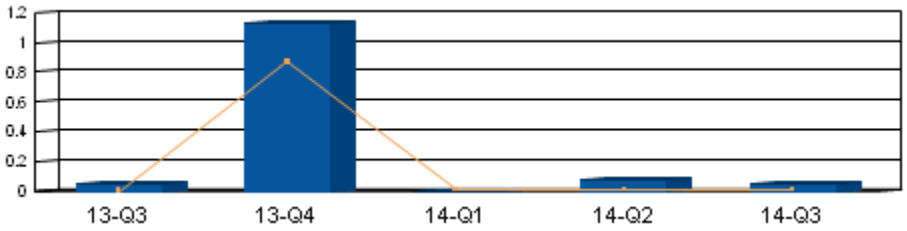
Indicator: VRE (Vancomycin-resistant Enterococcus)



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

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0.05 per 1000 patient days which represents 2 cases. We experienced 1 case in October and 1 case in December. This is a decrease from Quarter 2 when we had 3 cases and our rate was 0.08 per 1000 patient days.

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 SUPPORTING INDICATOR

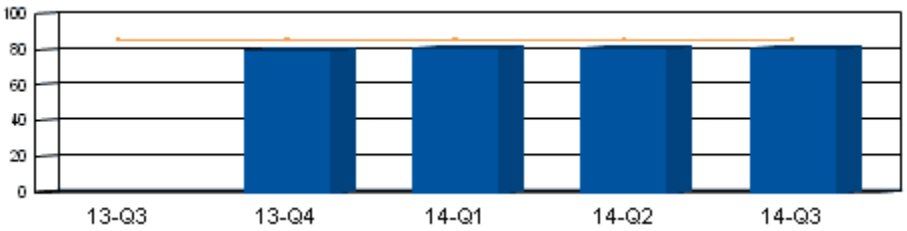
Enterococci are bacteria that live in the gastrointestinal tract of most individuals and generally do not cause harm. Vancomycin-resistant enterococci (VRE) are strains of enterococci that are resistant to the antibiotic vancomycin. If a person has an infection caused by VRE, such as a blood infection,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

Interpretation - Patient And Business:

This indicator is a result of cleaning audits by a third party company Westech. These ongoing audits are performed semi-annually.
The most current results are from August 2013 audit report with a score of 81%. This score has remained consistent however below our target of 85%.

Actions & Monitoring Underway to Improve Performance:

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

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

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%

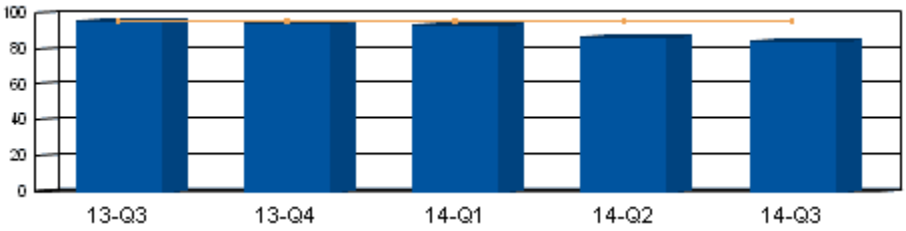
Kingston General Hospital

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-Q3	95	**95**
13-Q4	94	**95**
14-Q1	93	**95**
14-Q2	86	**95**
14-Q3	84	**95**

Interpretation - Patient And Business:

Patient Perspective: IPAC Service continues to train new hygiene auditors. In the last quarter we have added 14 new auditors. IPAC Service recognizes that it does take new auditors time to become skilled with the device and how to identify and capture all hand hygiene opportunities. Auditors are encouraged to contact us with any questions or for additional support if needed. In addition, ICP's now check in with the auditors on their unit rounds. Through this checking in process we have identified a number of situations where further clarification of interpreting activities during the auditing process was required.

Business Perspective: For this quarter we captured 1398 indications of Moment 1(before initial patient/patient environment contact).

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

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%

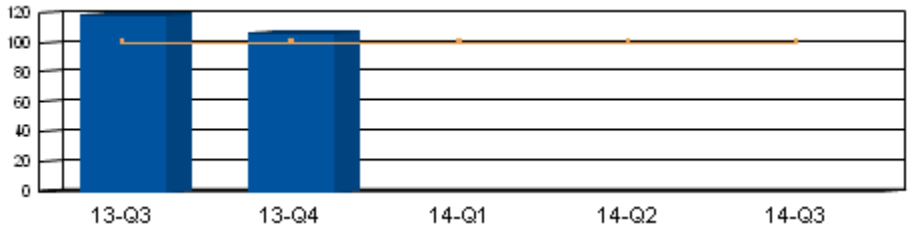
Kingston General Hospital

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-Q3	119	**100**
13-Q4	106	**100**
14-Q1		**100**
14-Q2		**100**
14-Q3		**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:

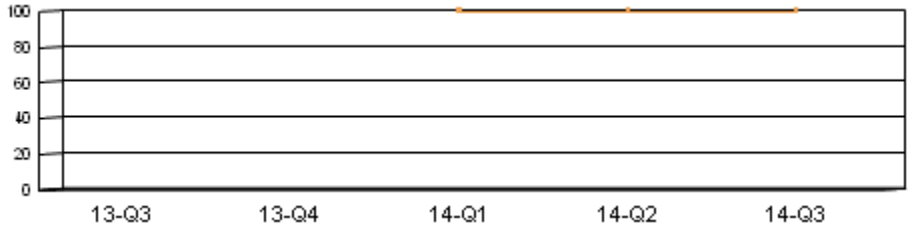
The most recent data available data from CIHI is Q4 of fiscal 12/13. The HSMR for Q4 was deemed not significant by the Canadian Institute for Health Information (CIHI) and the HSMR for the complete fiscal year 12/13 was also deemed not significant. The Canadian Institute for Health Information (CIHI) 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 SUPPORTING INDICATOR

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

Interpretation - Patient And Business:

This indicator has been in development and feasibility assessment. It is now ready for implementation in the later part of Q4. Of note, this indicator will be a primary line indicator in the QIP 2014/15 as per HQO.

Definition: COMMENTS: Dr. David Zelt QIP INDICATOR

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%

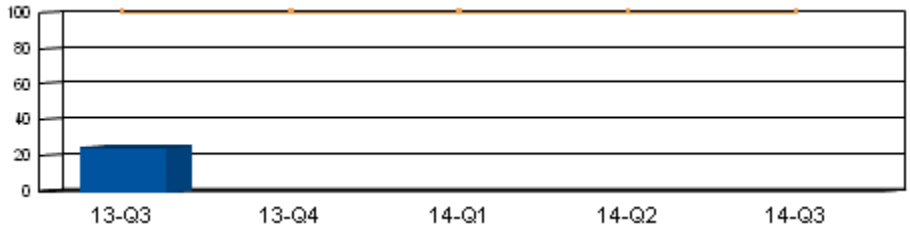
Kingston General Hospital

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

Actions & Monitoring Underway to Improve Performance:

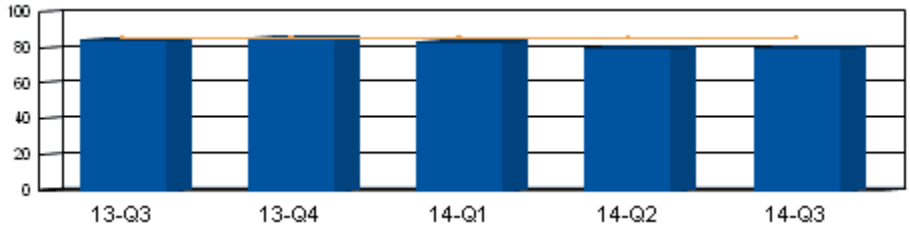
Mortality reviews, although completed, were not done in the time frame of a quarterly review period. Over 2 years of review, there have been no recommendations coming forward. As of Q4 last year, the process was redesigned to have the Departments to review mortality from the most recent quarter rather than historically identified through HSMR (up to 12-18 months later). A focus on mortality related to sepsis and 5 day post major surgery will align to the most current MoH initiatives. As a result, for Q3 of this year, October and November mortality data were forwarded to Departments for review. December data will be forwarded by the end of January 2014 allowing for a Q3 status close of Q4.

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

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-Q3	84	85
13-Q4	85	85
14-Q1	83	85
14-Q2	80	85
14-Q3	80	85

Interpretation - Patient And Business:

The Q3 results are the results from the July 2013 -
Sept 2013 which are the most recent results from NRC + Picker Patient Satisfaction Survey which is conducted on discharge. Although there is a slight decrease in the result, the results do represent consistency. Our leadership will continue to work with our staff.

Actions & Monitoring Underway to Improve Performance:

Our auditing of our cleanliness program is supporting these results. Results of survey continue to be shared with our team with an emphasis on the importance of first impression and daily room cleaning.

Definition: DATA: Astrid Strong Comments: Jim Jeroy SUPPORTING INDICATOR

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%

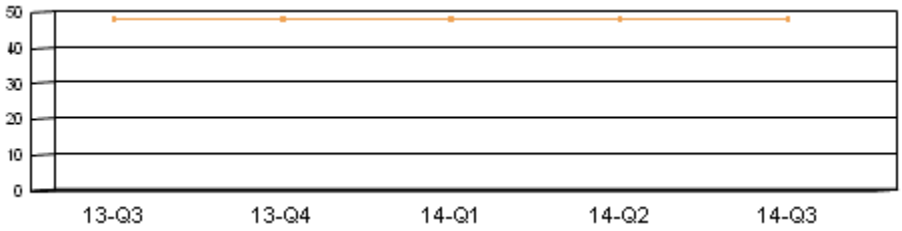
Kingston General Hospital

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

Interpretation - Patient And Business:

The recent survey has been received and reviewed by the Executive and Board. Action plans are being developed by managers and directors to address top concerns identified. Additionally, corporate level indicators from the survey are under review for themes and alignment with frontline, manager and director action plans.

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

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%

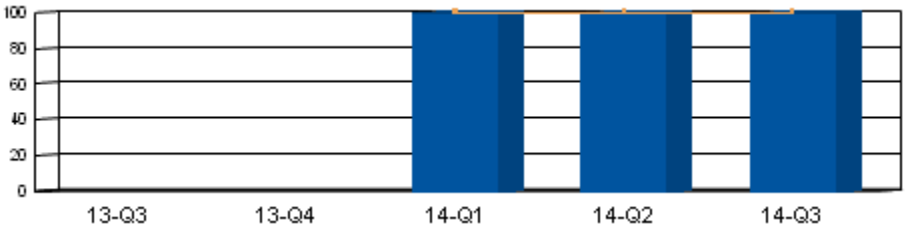
Kingston General Hospital

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

Interpretation - Patient And Business:

There were 2 Quality of Care/Critical Incident reviews held in Q3. A Falls incident and a Care/Treatment event. Of the 11 resulting recommendations, 5 are complete and 6 are ongoing/current.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong SUPPORTING INDICATOR

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 Q3 there were 3 Gridlocks, with duration ranging from 1 to 8 days, compared to 1 in Q2 and 5 in Q3 of 2012/13. Eight of 20 improvement opportunities approved by the Patient Flow Task Force are actively being addressed, with 3 moving into the sustainability phase. Of the 31 supporting indicators, with most recent data (5 are delayed reporting by a quarter), 65% are yellow (n=8) or green (n= 12), and 35 % are red (n=11). Sixty five percent of all indicators are trending positively. Of the red indicators, again 65% (n=7) are trending favourably, and the four indicators that are trending unfavourably pertain to the percent ALC days, the wait times of low acuity non admitted patients in the ED, and orthopedic 90%ile wait time (excluding hip/knee replacement). Three services, Neurology, Ob/Gyne and Gastroenterology are services that did not meet ELOS in Q3.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** In October, the PFTF endorsed launch of 3 new improvement cycles focused on predicted discharge, discharge planning and consult processes for allied health disciplines. These tactics were selected for anticipated impact to length of stay and readmission. Teams have been configured and PDSA cycles are in process of design and pilot. Program and Departments are also working on tactics that will influence performance of the supporting indicators. Collaboration with partners (CCAC, Providence Care, regional hospitals) are key to enabling access to Stroke rehab, and alternate locations in community, region or with long term care homes/convalescent care. Focused effort on bed map redesign was launched and will continue through Q4 as enabler to optimizing underutilized but misaligned beds and to support flow particularly of Medicine patients out of ED.

3. **Are we on track to meet the milestone by year end?** Four of the original 5 teams will have completed the PDSA and moved into sustainability phase. The 3 launched in Nov/13 are likely to remain in active phase. This is a sound process for embedded changes in practice.

4. **What new tactics are planned to ensure this milestone is met?** In Q4, the emphasis will be of focusing time and resource internally to complete Gridlock PDSAs and program tactics, such as Rapid Assessment Zone in ED; navigation roles, etc. In Feb/14 the PFTF will determine if/which new opportunities are launched into a next 120 day improvement cycle. There will also be completion of the bed map redesign for implementation in 2014/15. Externally we will work with the CCAC/LHIN/SECHEF on addressing the ALC challenge, and will collaborate with HDH on work with their model of support for lower acuity patient visits.

Kingston General Hospital

MS #03

			13-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
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	Y	Y	Y	
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	Y	Y	R	R	Y	↑
		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	Y	↑
		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	R	R	Y	↑
		General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	Y	R	R	G	G	↑
		All Paediatric Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	Y	↓
		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	Y	↓
		Orthopedic Surgery (Excluding Total Hip and Knee Replacements) - 90th Percentile Wait Time (Days)	Y	Y	R	R	R	↓
		Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)	G	G	G	G	G	↑

33	13-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
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	R	R	R	↓
Overall - Acute Average Length of Stay Days (Based on HSAA)	Y	G	G	G	G	↑
Overall - Acute Average Length of Stay vs ELOS Variance in Days	G	Y	G	G	G	↑
Percent of Clinical Services Meeting or Exceeding ELOS Target	R	R	Y	G	Y	↑
Number of Inpatient by Program Floor Assignment Patient Days Within Budget	N/A	N/A	Y	G	G	↑
Reduce the Number of Avoidable Admissions	N/A	N/A	R	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	Y	R	↑
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs	Y	Y	Y	G	Y	↓
Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↑
Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	R	R	Y	Y	R	↓
Percent of Non-Admitted High Acuity Patients Treated Within a Wait Time Target of <8hrs (CTAS 1-2) & <6hrs (CTAS 3)	G	G	G	G	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	G	Y	Y	↓

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

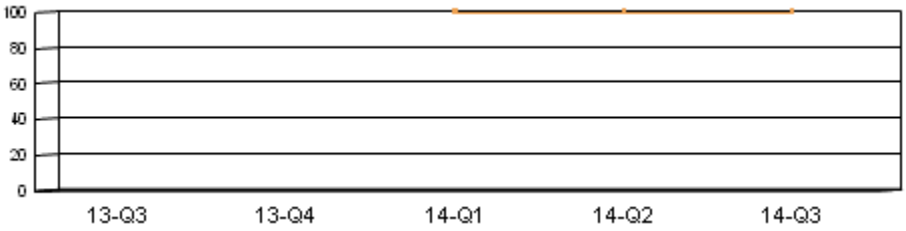
Kingston General Hospital

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

Interpretation - Patient And Business:

In Q3 there was 3 Gridlocks, ranging from 1 to 8 days in duration. This is 2 more relative to Q2 and 2 fewer relative to Q3 2013. The duration of codes is on average greater than last year. Work on the corporate VSM process which was launched in May, and continues with oversight of 8 priority processes. Two of the improvement cycles (transfer of admission information for bed allocation and transfer of admission between units on transfer) have been successfully completed and have transitioned to sustainability mode. A third cycle will with certainty be completed in Q1. The remaining 5 are progressing with regular update to PFTF. Project teams are typically interprofessional in makeup 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:

The PFTF, 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. 3 PDSA's are progressing within the 120 cycles and 2 have extended well into a 240 day period. Both are being enabled with greater executive engagement. In February the PFTF will do an overall review of the VSM work and determine if there is capacity to undertake more or different improvement cycles. There is a new regional group, led by CCAC and with active support from KGH that is addressing systemic issues with patient flow (long stay patients in ED; ALC).

Definition: COMMENTS: Eleanor Rivoire STRATEGY & QIP INDICATOR

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%

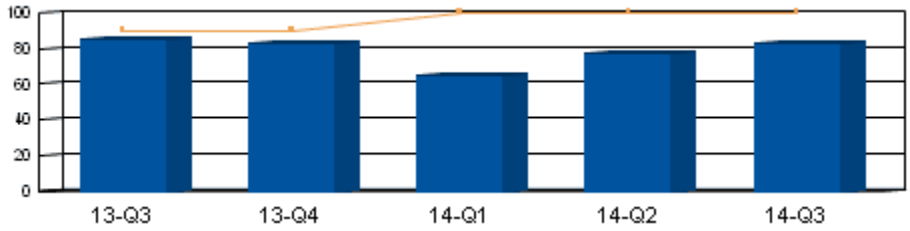
Kingston General Hospital

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

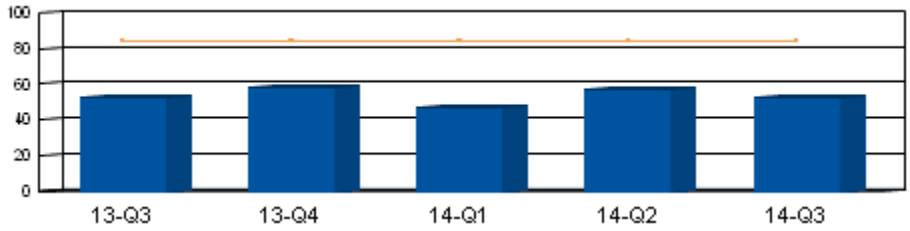
There has been a steady increase in the number of services meeting the 90th percentile wait time target in Q3. 9 of 52 clinical areas have a status of Red with respect to meeting their wait time targets (1 general surgery; 1 peds oral surgery; 4 orthopedic; 1 Plastic surgery; 1 urology, and 1 DI (MRI). 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: DATA: Decision Support COMMENTS: John Lott SUPPORTING INDICATOR

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

Interpretation - Patient And Business:

For Q3 this indicator continues to achieve its green performance target. There were 234 cancer procedures completed in this quarter with a 90% percentile wait time of 55 days in October decreasing to 46 days in December. This service has also successfully exceeded its target of 90% in meeting access targets for service with a 92% standing for this quarter.

Actions & Monitoring Underway to Improve Performance:

The SPA and Oncology program leadership continue to work collaboratively in monitoring 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. The recruitment of a new ENT Head Surgeon and Thoracic Surgeon will assist in meeting additional target volumes.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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

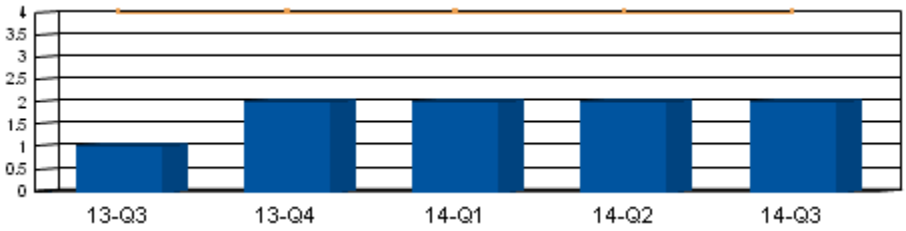
Kingston General Hospital

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

Interpretation - Patient And Business:

At the end of Q3 F14, KGH is meeting 2 of the 4 CCO Access to Care contract indicators. Specifically, KGH is meeting the Systemic referral to first consultation and the radiation consultation to start of radiation treatment indicator (Q3 F14 performance is 100%). The other two indicators, Radiation referral to first consult and Systemic Consult to start of treatment are not being met. There was improvement, however, in the referral to first consult in radiation during Q3 - moved from 64% to 72%.

Consultation interval performance was positively impacted due to both Divisions being fully staffed as of end of September 2013. The Division Heads for both Radiation and Systemic are 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. Monthly audits continue to ensure there are no avoidable delays in treatment. As of Q3, no regional cancer centre is meeting this target. Provincial discussions are underway to determine the validity of this indicator in F15.

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)

Actions & Monitoring Underway to Improve Performance:

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

Formal improvement initiatives were launched in F14 to address data quality, capacity, process or accountability issues impacting on KGH's ability to meet these access targets. This should help move KGH closer to meeting the access targets in F15.

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

Definition: DATA: Decision Support - Cancer (K. Balchin) COMMENTS: Brenda Carter SUPPORTING INDICATOR

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

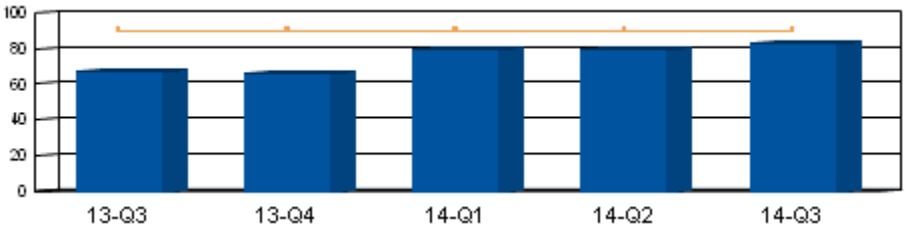
Kingston General Hospital

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-Q3	67	**90**
13-Q4	66	**90**
14-Q1	79	**90**
14-Q2	79	**90**
14-Q3	83	**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 Q3 F14, KGH is not meeting this target. However, steady improved performance is evident compared to Q4 F13 results. Given that the indicator performance reflects performance over the previous 12 month period, KGH has not yet achieved target performance of 90% despite exceeding 90% for November and December 2013.

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:

For the months of October, November and December 2013, KGH's performance was 88%, 95% and 94% respectively. This is the best three months in our surgical oncology history and a remarkable improvement compared to Q3 F13 (66%, 70%, 65%). At end of Q3 F14, KGH did not meet the Cancer Care Ontario Cancer Surgery contracted target of 90% “Year to Date”; however, these exceptional past three months have brought a 4% improvement in our YTD performance from 79% in Q2 to 83% in Q3.

CCO target in this indicator is 90% of cases meeting wait time target and only three out of 14 LHINS are currently achieving 90% or better (Central, Central East and Central West). The provincial average in the month of October 2013 (most current results available at this time) was 85% in all priority categories.

The Cancer Surgery Wait Time Improvement Team continues to be very active in its efforts to sustain the gains now that we've seen two months above 90%. Pro-active wait list management remains in place and collective efforts on behalf of surgeons, secretaries and the wait times improvement team are yielding positive results.

Quality assurance of priority assignments also continues. 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 maintaining target achievement.

Definition: DATA: Shankar Chowdhury COMMENTS: Brenda Carter SUPPORTING INDICATOR

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%

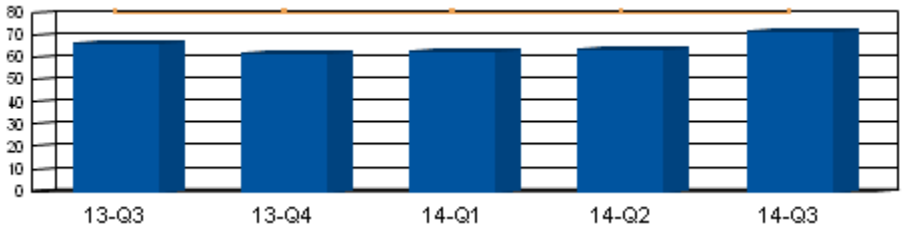
Kingston General Hospital

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-Q3	66	**80**
13-Q4	62	**80**
14-Q1	63	**80**
14-Q2	64	**80**
14-Q3	72	**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 Q3 F14, 72% of all patients referred to KGH are seen by a radiation oncologist within 14 days (compared to 64% in Q2). Improved access performance in Q3 related primarily to having all Radiation Oncology positions filled. A new report developed to flag cases that are scheduled to breach the 14 day target has been implemented and is closely monitored with action taken by Division Heads to work with the oncologists to book patients with the 14 day period to the extent possible. Additional work is underway to ensure referrals to radiation oncology are complete, avoiding unnecessary delays in collecting critical information after the referral has been received.

Actions & Monitoring Underway to Improve Performance:

A focused review of breast cancer referrals has been completed and a number of improvement opportunities are being implemented in Q3 and Q4.

Reasons for under-performance include process delays, booking/scheduling practices, early referral of post-surgical patients, incomplete information from referring source, and data quality. Referrals for patients requiring combined modality treatment also negatively impact wait times.

Improving this performance is high priority and sponsored by the RVP, PMD and Medical Head of the Radiation Treatment Program and is also on the QIP for the Cancer Program in F14.

Definition: DATA: Katelyn Balchin COMMENTS: Brenda Carter SUPPORTING INDICATOR

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%

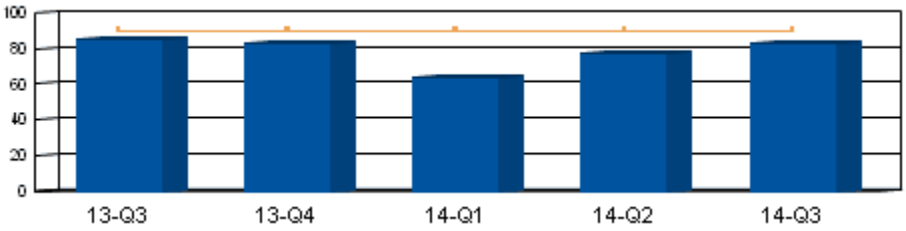
Kingston General Hospital

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-Q3	85	**90**
13-Q4	83	**90**
14-Q1	64	**90**
14-Q2	77	**90**
14-Q3	83	**90**

Interpretation - Patient And Business:

Improvement in services meeting the 90th percentile wait time target continues to trend positively for Q3. There are now 39 of 47 wait time services meeting the target (continuous improvement focused on following service targets-1general surgery; 1 peds dental; 3 adult orthopedic; 1 Plastic surgery; 1 ped ortho and 1 urology).

Actions & Monitoring Underway to Improve Performance:

The Wait Time Initiative Committee and SPA leadership continues to focus on sustainability of initiatives that should contribute to ongoing improvements in Q4.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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%

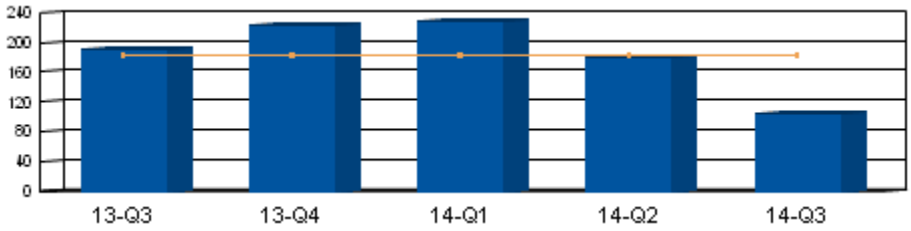
Kingston General Hospital

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-Q3	192	**182**
13-Q4	224	**182**
14-Q1	229	**182**
14-Q2	181	**182**
14-Q3	104	**182**

Interpretation - Patient And Business:

In this quarter there were 243 completed cases (80 more than Q2) with 90% percentile wait times of 197 days in October decreasing to 168 days in December. In Q3 there were 6 completed cases with target wait times between 230- 340 days which influenced the median and average wait times. There were 15 cases cancelled in this quarter for the following reasons; incorrectly booked (1), insufficient time (1), no bed (1), change in medical condition post PSS (4), emergency case substitution (1), patient not NPO (1),surgeon's decision (1), patient refusal (1) unexpected surgical complication previous case (5).

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 SUPPORTING INDICATOR

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

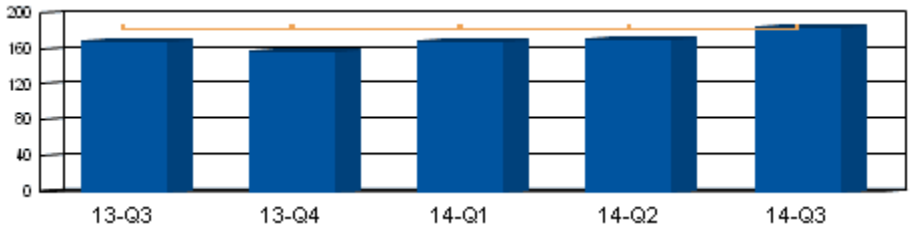
Kingston General Hospital

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-Q3	167	**182**
13-Q4	157	**182**
14-Q1	167	**182**
14-Q2	170	**182**
14-Q3	183	**182**

Interpretation - Patient And Business:

For Q3 this indicator just missed the green corridor by one day although the target has been slowing increasing over the last four quarters. Influencing this change in target was the completion of 6 pediatric cases that had exceeded waiting times between 187-582 days.

Pediatric surgical service activity for this quarter is the following:

General Surgery (2 completed cases):
All completed cases were within acceptable wait time targets. There are currently 3 cases on the wait list within target times.

Orthopedics (7 completed cases):
For this service the 90% percentile was 99 days in October increasing to 124 days in December. One completed case had a wait time of 187 days. There are currently 17 pediatric ortho cases on the wait list with 16 cases over target between 216 and 1378 days.

Urology (12 completed cases):
The 90% percentile for pediatric urology was 265 days in October decreasing to 43 days in December. There are 26 cases currently waiting on the list with only 1over target by 59 days.

All peds ENT both sites (116 completed cases):
For this service the 90% percentile for October was 174 days trending positively to 164 days in December. There are currently 153 cases on the waitlist with 38 of these cases already over the 182 day target between 250 and 787 days waiting.

Actions & Monitoring Underway to Improve Performance:

There has been the successful recruitment of another pediatric surgeon for the general surgery service commencing in the next qureater.

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

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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

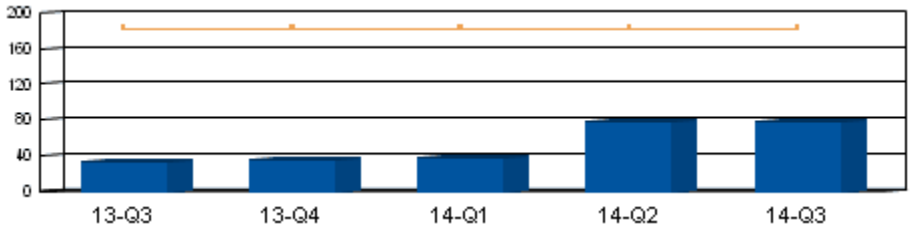
Kingston General Hospital

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

Interpretation - Patient And Business:

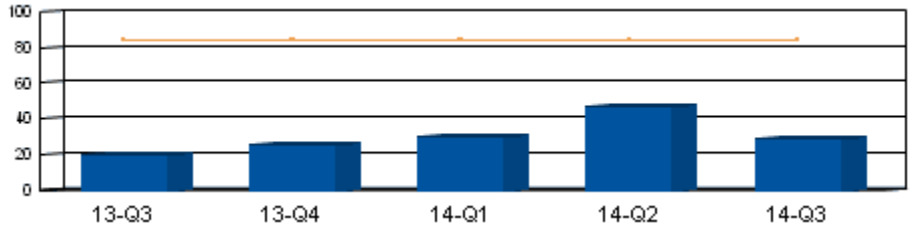
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: DATA: Decision Support COMMENTS: Julie Caffin SUPPORTING INDICATOR

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-Q3	20	**84**
13-Q4	26	**84**
14-Q1	30	**84**
14-Q2	47	**84**
14-Q3	29	**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 SUPPORTING INDICATOR

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

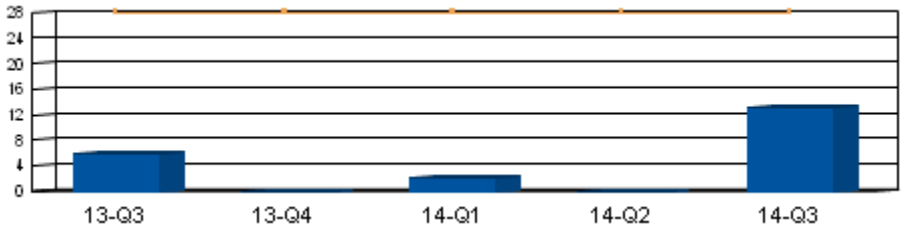
Kingston General Hospital

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-Q3	6	**28**
13-Q4	0	**28**
14-Q1	2	**28**
14-Q2	0	**28**
14-Q3	13	**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 SUPPORTING INDICATOR

Coronary angioplasty is a procedure which unblocks narrowed arteries by inserting a small balloon into each artery and inflating the balloon at the site of the blockage. Often, a small metal tube (stent) is permanently placed in the artery to help keep the artery open. This allows blood to flow freely through the artery. For coronary angioplasty procedures, the Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and interventional cardiologist decide to proceed with the procedure, until the time when the actual procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the procedure or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. The wait is calculated for each patient who received treatment within the most current time period, for a particular service area and hospital. The 90th percentile wait time is defined as the point at which 9 out of10 patients have completed the treatment.

Target: Baseline 08/09: 12 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days. Target 12/13: 28 Days, Target 13/14: 28 Days Perf. Corridor: Red >32 Yellow 29-32 Green <=28

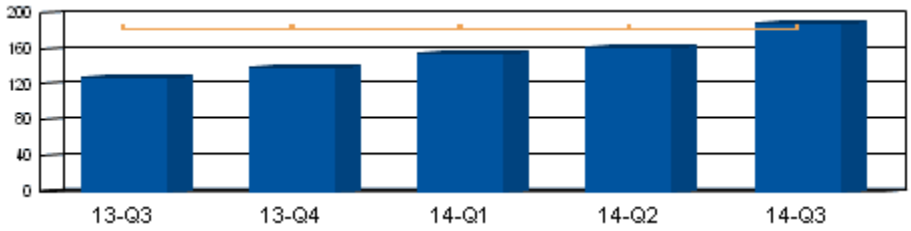
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q3	127	**182**
13-Q4	139	**182**
14-Q1	154	**182**
14-Q2	161	**182**
14-Q3	188	**182**

Interpretation - Patient And Business:

For Q3 this indicator for the first time since 2010/2011 has not met its green target There were 77 completed cases with a 90% percentile of 212 days in October increasing to 233 days in December. In this time period there were 18 cancelled scheduled cases due to emergency case inserted (1), no available bed (7), insufficient time (1), patient non-compliant (2), patient refused procedure (1), surgery no longer required (1) and unexpected surgical complications with the previous cases (3). Other factors influencing this quarter was the impact of Q2 reduced OR time/incomplete cases thereby contributing to already increasing wait time days for patients and the completion of 2 over target cases (227 and 265 days).

There are currently 401 KGH patients on the wait list for the total primary joint program. This volume includes 171 patients waiting for primary hip replacements with 81 already exceeding the 182 day target as well as 230 patients waiting for primary knee replacement with 119 of them exceeding the wait time target.

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to support physician office administration in monitoring and managing the wait lists appropriately. Wait times are tabled on the SPA program council for review along with the Wait Times/Quality Based Procedure Committee. The creation of a Cancellation Task working group inclusive of patient experience advisors, secretaries and SPA leaders will be focusing on reducing cancellations.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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

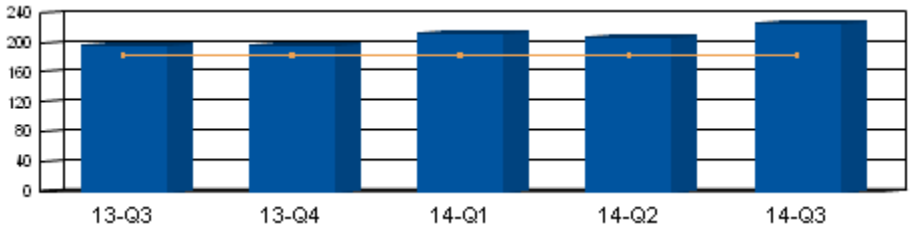
Kingston General Hospital

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-Q3	197	**182**
13-Q4	196	**182**
14-Q1	212	**182**
14-Q2	206	**182**
14-Q3	227	**182**

Interpretation - Patient And Business:

For Q3 there were 307 completed cases with a 90% percentile wait time of 202 days in October increasing to 219 days in December. In this time period there were 7 cancelled scheduled surgery cases of which 2 cases were patient related (refused procedure, unavailable.) with 4 remaining cases cancelled for the following : 1 change in medical condition,1 insufficient time, 1 emergency case inserted, and 2 unexpected surgical complication from the previous case. Also influencing these wait times was the completion of 7 case procedures with exceeded wait times between 203- 398 days.

There are currently 549 patients on the wait list with 50% 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. SPA leadership in working with the Division Head for Orthopedics are reviewing OR scheduled times to ensure that focus is balanced between the QBP procedure volumes and other non-arthroplasty procedures.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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

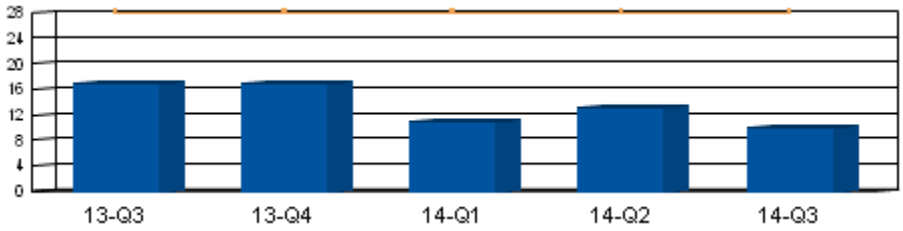
Kingston General Hospital

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-Q3	17	**28**
13-Q4	17	**28**
14-Q1	11	**28**
14-Q2	13	**28**
14-Q3	10	**28**

Interpretation - Patient And Business:

KGH deals primarily with inpatient, emergency room cases, and timed follow up procedures. The wait time for these should be low.

Actions & Monitoring Underway to Improve Performance:

A low wait time is what is expected for the specific patient population.

Definition: DATA: Decision Support COMMENTS: Karen Pearson SUPPORTING INDICATOR

For diagnostic CT scans, the Ontario Wait Time Strategy measures the wait time from when a CT scan is ordered, until when the actual exam is completed. This interval is typically referred to as from "decision to treat" to "treatment". A patient with an existing condition may be pre-booked for a follow-up exam or a series of follow-up exams at a later date, resulting in apparently long wait times for those particular exams. Please note, as of January 1st, 2008 these cases are excluded from publically reported CT wait time data as well scans done on an emergency basis. The 90th percentile wait time is defined as the point at which 9 out of 10 patients have completed the exam.

Target: Baseline 08/09: 26 days, Target 09/10: 28 days, Target 10/11: 28 days, Target 11/12: 28 days. Target 12/13: 28 Days, Target 13/14: 28 Days Perf. Corridor:Red >32 Yellow 29-32 Green <=28

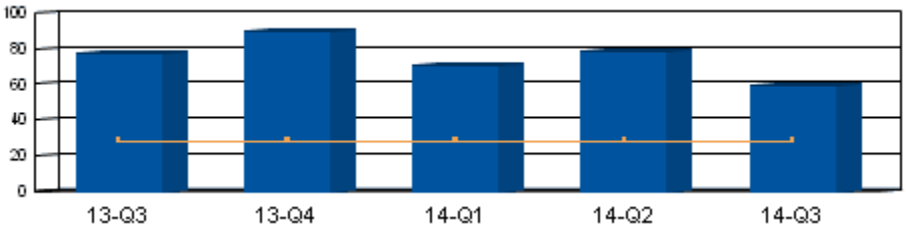
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

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



	Actual	Target
13-Q3	77	**28**
13-Q4	90	**28**
14-Q1	70	**28**
14-Q2	78	**28**
14-Q3	59	**28**

Interpretation - Patient And Business:

The wait time has dropped significantly since the last quarter. I am cautiously optimistic that we can maintain this trend.

Our biggest challenge has been staffing. There has been a tremendous amount of sick time in the department which has caused us to reduce hours and this ultimately increases the wait time because of reduced patient throughput. Additional staffing has been recently hired. Lack of booking staff is another huge issue that directly impacts the wait times. Staffing issues in this area have been an ongoing problem that has negatively impacted efficiency.

Actions & Monitoring Underway to Improve Performance:

Hire additional PT MRI technologist staff to ensure coverage of all operational hours.

Re-organize booking desks to allow for 1.5 FTE clerical support to MRI

MRI efficiency, decreased wait times and maximum operational hours all depend on having skilled and adequate numbers of staff.

The patient's journey of care is directly impacted when there is a delay in being able to access required critical diagnostic procedures.

Definition: DATA: Decision Support COMMENTS: Karen Pearson SUPPORTING INDICATOR

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

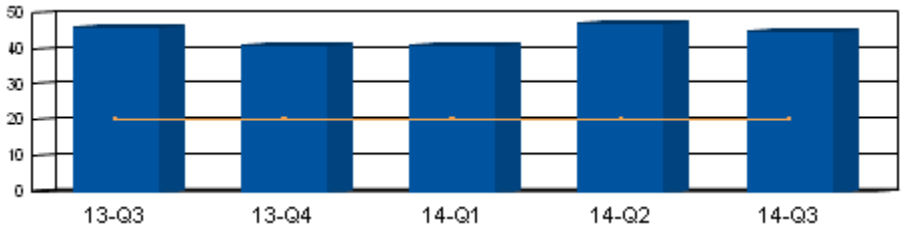
Kingston General Hospital

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-Q3	46	20
13-Q4	41	20
14-Q1	41	20
14-Q2	47	20
14-Q3	45	20

Interpretation - Patient And Business:

Patients waiting for transfer to long term care (ALC-LTC) continue to make up the majority of the ALC numbers, with those waiting for supervised or assisted living also having a larger than usual complement. Barriers to discharge include: community crisis placements, reduced bed availability within the LHIN, availability of patient choice for accommodation, and the need for secure accommodation. Patients waiting for assisted or supervised living tend to originate from the mental health program and are wait-listed for specialized group homes.

Actions & Monitoring Underway to Improve Performance:

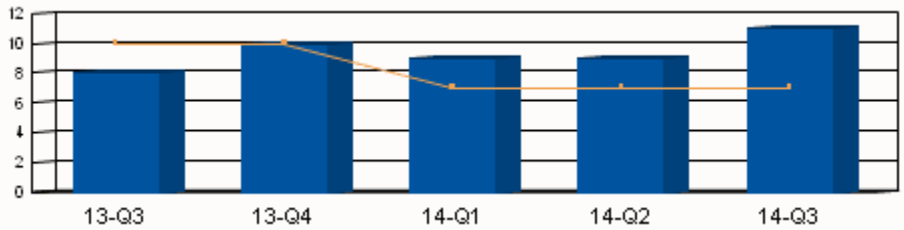
Weekly meetings are held with CCAC to review the wait lists. Wait lists are more accurate as a result. These meetings also provide an opportunity to discuss opportunities to reduce barriers and to escalate case-specific issues that arise e.g. numbers of bed choices. Monthly geriatric rounds have resulted in better planning for patients returning to the community or waiting for LTC i.e. involvement of the Behavioural Response Teams and behavioural supports staff.

Definition: DATA: Adrienne Leach COMMENTS: Adrienne Leach SUPPORTING INDICATOR

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

Indicator: Percent ALC Days



	Actual	Target
13-Q3	8	10
13-Q4	10	10
14-Q1	9	7
14-Q2	9	7
14-Q3	11	7

Interpretation - Patient And Business:

Ongoing conversion of patients from acute to ALC, in addition to the barriers to discharge related to capacity within the community, are resulting in both higher numbers of ALC patients, and increased lengths of stay for this patient population.

Actions & Monitoring Underway to Improve Performance:

Regular communication with CCAC and SELHIN is occurring to investigate opportunities that will address the system-wide challenges with the ALC situation.

In the short term, in addition to regular communications and planning processes, there are case by care evaluations of barriers that drive the extended lengths of stay for these patients.

Definition: DATA: Decision Support COMMENTS: Adrienne Leach SUPPORTING INDICATOR

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%

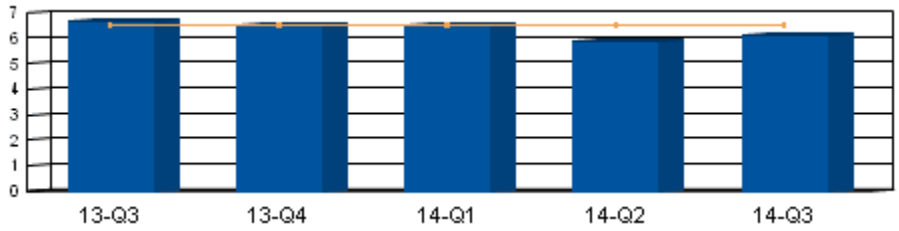
Kingston General Hospital

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 Days (Based on HSAA)



	Actual	Target
13-Q3	6.7	**6.5**
13-Q4	6.5	**6.5**
14-Q1	6.5	**6.5**
14-Q2	5.9	**6.5**
14-Q3	6.1	**6.5**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The average length of stay for Q3 at 6.1 days is 0.4 days below the target of 6.5 days, which again represents excellent 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 .8 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 SUPPORTING INDICATOR

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

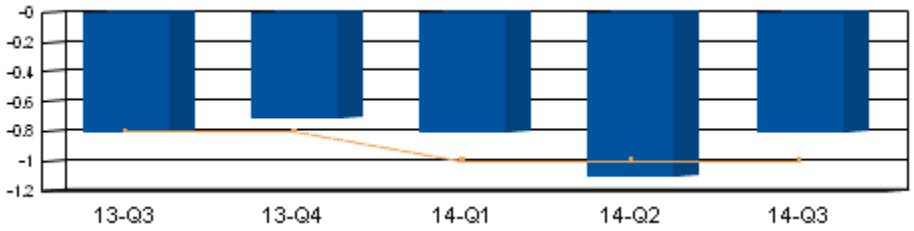
Kingston General Hospital

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-Q3	-0.8	**-1**
13-Q4	-0.7	**-1**
14-Q1	-0.8	**-1**
14-Q2	-1.1	**-1**
14-Q3	-0.8	**-1**

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q3. The 0-.8 day variance for Q3 (fiscal 13/14) indicates that our overall actual length of stay remains below (or better) than our expected length of by 0.8 of a day, just slightly below our target of -1.0 days. It is important to note that this is calculated on an overall basis. There remains opportunity in 3 of 18 services to achieve expected length of stay. The service of Neurology, Obs/gyn, and Gastroenterology.

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 SUPPORTING INDICATOR

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

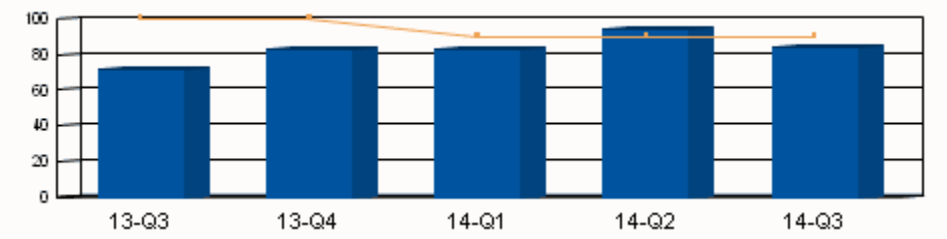
Kingston General Hospital

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-Q3	72	**100**
13-Q4	83	**100**
14-Q1	83	**90**
14-Q2	94	**90**
14-Q3	84	**90**

Interpretation - Patient And Business:

As of Q3 (fiscal 13/14), 84 percent of services (15 of 18) are achieving (or outperforming) their expected length of stay. Although we have dipped slightly in the quarter, the 3 services that are at or slightly above their expected don't represent a material difference. The services that are currently not at its expected length of stay is Neurology, Obs/Gyn, and Gastroenterology. 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 SUPPORTING INDICATOR

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%

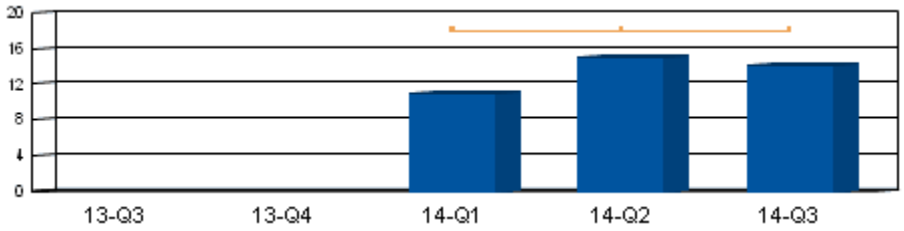
Kingston General Hospital

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

Interpretation - Patient And Business:

Clinical leaders continue to oversee the occupancy of units, and support patient flow making use of overcapacity beds with a program, and in others with off servicing patients to units outside of the program. Medicine continues to be the program that experiences greatest challenge with clinical surge. Work 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). Most recent emphasis is on discharge prediction/planning. The role and accountability of bed allocators continues to be profiled and supported to optimize access and use to all space.

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 is well underway with each division in each medical/surgical department reviewing utilization trends and projecting needs. Anticipate decision regarding realignment of beds by end of Q4 to make best use of bed resources and geographical space.
In response to a variety of discharge challenges, there has also be acknowledgement at system level of the challenges with patient flow, and a new task team, led by CCAC was launched in Q3.

Definition: Data: Decision Support COMMENTS: Eleanor Rivoire SUPPORTING INDICATOR

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 Red: <=7 Yellow: 8-10 Green >=10

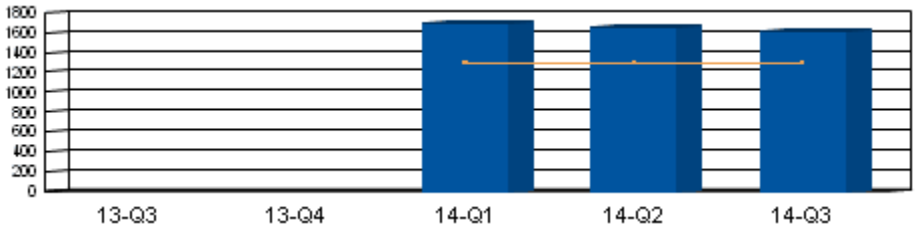
Kingston General Hospital

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 Admissions



	Actual	Target
13-Q3		
13-Q4		
14-Q1	1,701	**1292**
14-Q2	1,661	**1292**
14-Q3	1,610	**1292**

Interpretation - Patient And Business:

While demonstrating a downward trend (5% over 2 quarters), the indicator is not yet near an acceptable corridor of performance. As part of the Gridlock VSM initiative, and in Q3 specific improvement cycles are focused on eliminating delay with assessments and decision making of patients in ED, with the thought that this could reduce admissions; and to review and modify the discharge planning processes to enable better engagement of care team; families; and community based supports to support successful discharge, transitions and ongoing support in the community. At the Joint Quality & Utilization Committee there is also attention given by each Medical Department/Division to readmission rates, and ways to support program processes and to enlist primary care providers. The Decision Support team and Concurrent reviewers are key supports to these processes.

KGH is active involved in the work of 2 Health Link teams (Kingston and Rural Kingston) as they work on ways to improve community/regionally based services (Mental Health redesign; CSR teams) with the goal of minimizing individuals having the need to present to the ED and/or be readmitted. There is good planning underway however the impact of work and change with this system innovation is not great as yet and outcomes were likely overly ambitious.

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 SUPPORTING INDICATOR

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

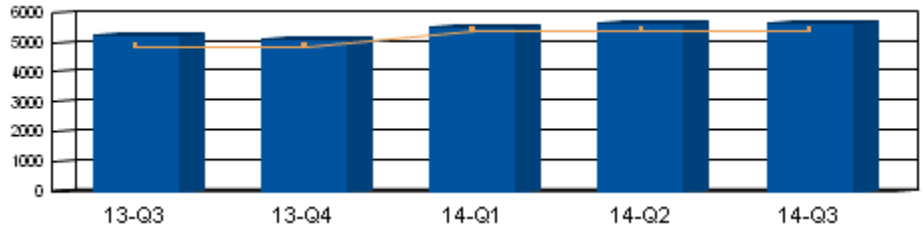
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Total Inpatient Admissions



	Actual	Target
13-Q3	5,256	**4850**
13-Q4	5,130	**4850**
14-Q1	5,514	**5398**
14-Q2	5,671	**5398**
14-Q3	5,631	**5398**

Interpretation - Patient And Business:

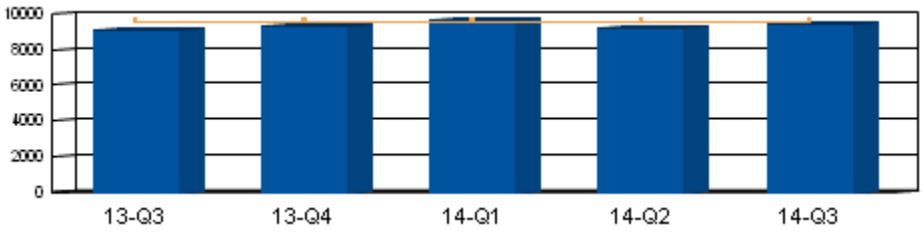
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

Definition: DATA: Decision Support COMMENTS: John Lott SUPPORTING INDICATOR

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-Q3	9,080	**9556**
13-Q4	9,272	**9556**
14-Q1	9,609	**9579**
14-Q2	9,140	**9579**
14-Q3	9,407	**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 SUPPORTING INDICATOR

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

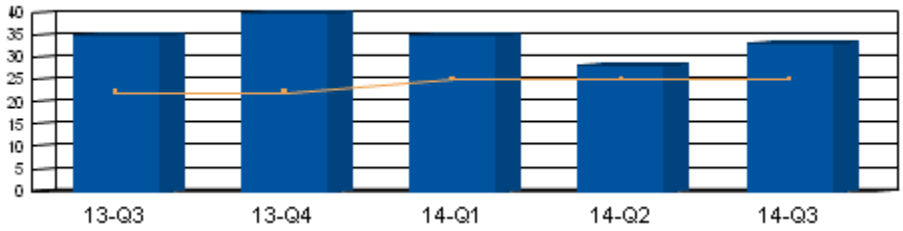
Kingston General Hospital

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-Q3	35	**22**
13-Q4	40	**22**
14-Q1	35	**25**
14-Q2	28	**25**
14-Q3	33	**25**

Interpretation - Patient And Business:

The Q3 result of 33 hours is 8 hours longer than the 25 hour target. Ninety percent of all patients admitted through the ED wait up to 33 hours to be transferred to an inpatient bed. Ten percent wait longer than this.

Actions & Monitoring Underway to Improve Performance:

LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning. LOS is being monitored at a corporate level and discussed at the Patient Flow Task Force meetings.
Strategy for this year includes identifying top sources of gridlock with recommendations on how to address opportunities identified. Work has started on 8 priorities. 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. Work is also being done around predicted discharges and a standardized discharge process.

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

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

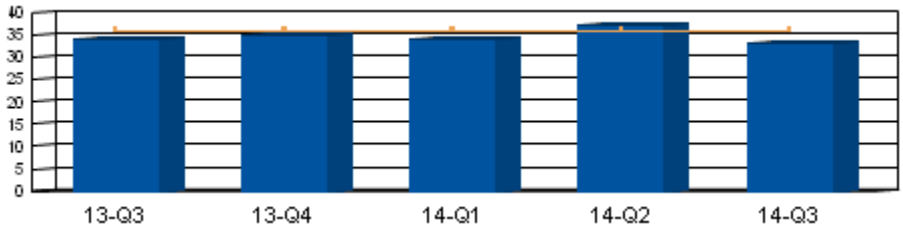
Kingston General Hospital

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

Interpretation - Patient And Business:

In Q3, 33 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. Q3 had an admission rate of 21% of all ED visits.
Emergency Department admitted patient volumes are above target by 388 admissions this quarter. Inpatient bed days are 1164 days in Q3.
Increasing LOS of admitted patients in the ED negatively impacts our capacity to see non-admitted patients in a timely fashion.

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 SUPPORTING INDICATOR

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%

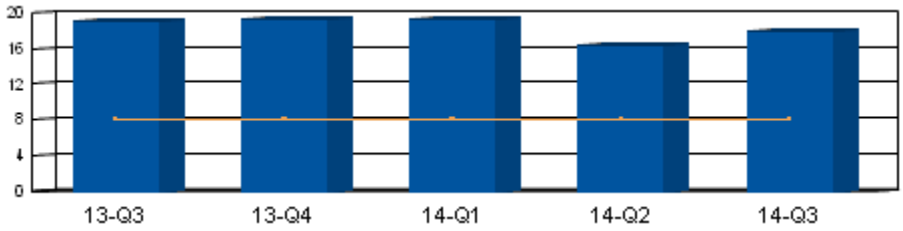
Kingston General Hospital

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-Q3	19.0	**8**
13-Q4	19.3	**8**
14-Q1	19.3	**8**
14-Q2	16.3	**8**
14-Q3	18.0	**8**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for patients admitted with complex conditions is 18 hours in Q3. Nine of ten patients are moved to an inpatient bed within 18 hours of arrival to the department while 10 percent wait longer than 18 hours. Inpatient days in the ED are at 1164 days in Q3. YTD this is 851 days over target and 550 days more than the same time last fiscal.

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 8 priorities were identified and teams are working through 90 to 120 day improvement cycles.

Definition: DATA: Decision Support COMMENTS: Julie Caffin SUPPORTING INDICATOR

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

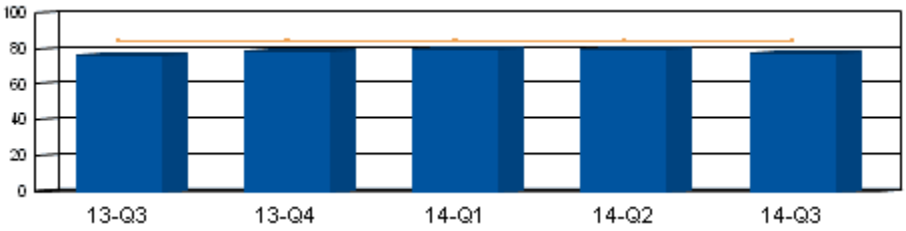
Kingston General Hospital

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-Q3	76	**84**
13-Q4	78	**84**
14-Q1	79	**84**
14-Q2	79	**84**
14-Q3	77	**84**

Interpretation - Patient And Business:

Based on Q3 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 22% of all ED visits. Inpatient days in ED were up this quarter at 1164 days. This is 851 days above target year to date. 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:

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 (when section E is full or not staffed) 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. A working gorup has put together a value stream map of flow through fast track and has identified opportunities to enhance flow.
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 SUPPORTING INDICATOR

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%

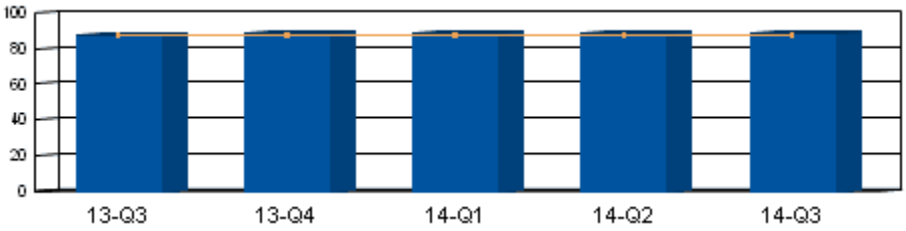
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on the Q3 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 5 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. Over 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 diagnostic tests has been the focus of our Rapid Assessment Zone (RAZ). RAZ runs daily between 0900 and 1700. Indicators are reviewed daily in our daily huddle.

Definition: DATA: Decision Support COMMENTS: Julie Caffin SUPPORTING INDICATOR

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%

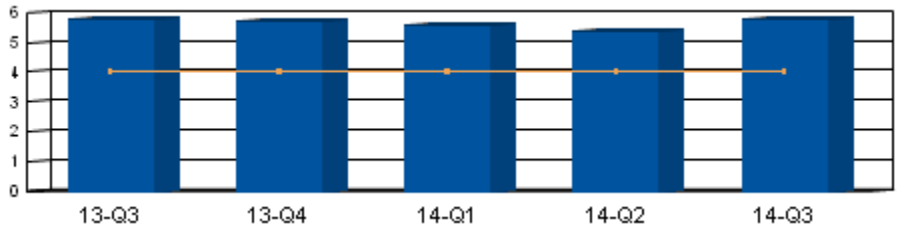
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on the 32 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 5.8 hours. The ability to see patients in this category is dependent on available assessment space. With the increase in overall volumes, admitted patients, increased inpatient bed days and a significant increase in higher acuity patients, these patients tend to wait longer for assessment after triage. Over 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:

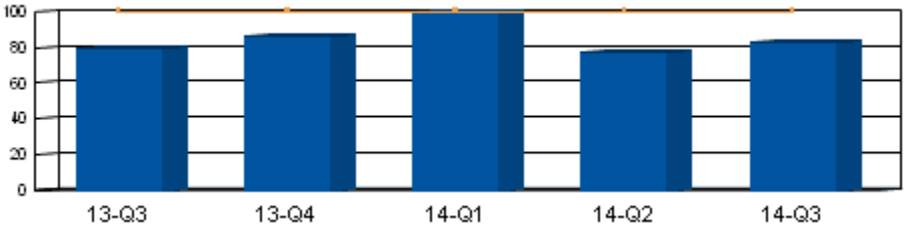
Daily huddles have been occurring with ED staff to identify opportunities for improvement using real time data from EDIS. A project manager has been hired to guide these changes in the ED. The team is also looking at ways to optimize stretcher and chair utilization to increase capacity within the department. A working group is looking at opportunities for improvement with flow of patients through fast track.

Definition: DATA: Decision Support COMMENTS: Julie Caffin SUPPORTING INDICATOR

This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and being discharged from the ED. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is discharged from the ED. 9 out of 10 patients whose conditions are minor or uncomplicated and require less time for treatment, diagnosis or observation will spend no more than 4 hours within the ER from the time they arrive and register to the time their visit is complete and they are discharged. CTAS (Canadian Triage & Acuity Scale) 4 or 5 are used to describe 'Minor or Uncomplicated'.

Target: Baseline 08/09: 7.0hrs, Target 09/10: 4hrs, Target 10/11: 4hrs, Target 11/12: 4hrs. Target 12/13: 4hrs, Target 13/14: 4hrs Perf. Corridor: Red >5 Yellow 4-5 Green >=4

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
13-Q3	79	**100**
13-Q4	86	**100**
14-Q1	100	**100**
14-Q2	77	**100**
14-Q3	83	**100**

Interpretation - Patient And Business:

As of Q3, 10 of 12 Wait Time Contracted volumes were on track. The two 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 SUPPORTING INDICATOR

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 process for auditing adoption of PFCC standards was launched in Q3 with first audit being done in Dec 2013. Corporate results were overall very encouraging with 4 of the 5 standards (Whiteboard, communication, hourly rounding, and patient led forums) exceeding 80%. Adherence to identification badge policy was 74%. Detailed results reveal inconsistency between areas/provider groups, and opportunity for reinforcement of expectations along with rationale for the standards.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** The auditing tool and process was refined and auditing began in December. The December results have been shared with leaders and managers for follow-up with staff; for information sharing in program and professional practice forums; and with offer of education supports as needed. Work continues in planning the transition from the original approach for communication (AIDET) to the Cleveland Clinic HEART (hear, empathize, acknowledge, respond, thank) program.

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 completion of the first audit has highlighted opportunities for refinement of the process and reports, and this will be followed up with the IT and auditing teams. Results will be shared on a monthly basis with leaders. The contract with the Cleveland Clinic for the HEART communication/engagement program is being finalized, along with the project charter which provides for launch of Train the Trainer education in Q4.

Kingston General Hospital

MS #04

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

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

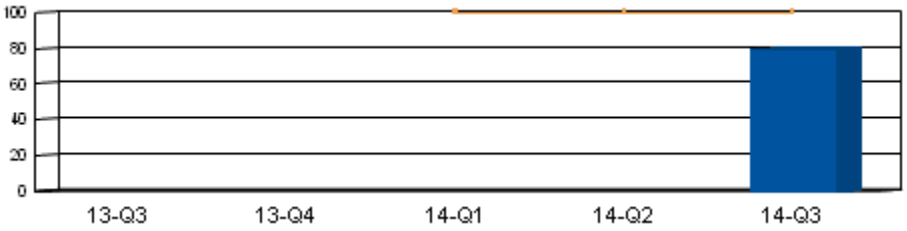
Kingston General Hospital

MS #04

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-Q3		
13-Q4		
14-Q1		**100**
14-Q2		**100**
14-Q3	80	**100**

Interpretation - Patient And Business:

Auditing tool is in use. First audit was completed in December. Corporate percentages all meet the 80% goal except for ID badges which is at 74%. Individual units and services are performing well but not all are meeting the 80% goal in each of the 5 standards.

Actions & Monitoring Underway to Improve Performance:

Directors and managers have received reports on their staff's compliance and will support improvement where needed. Online learning module is ready to be rolled out. Auditing continues with results reported monthly

Definition: DATA: COMMENTS: Darryl Bell STRATEGY & QIP INDICATOR

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 Q4.* RFP for KGH website, which includes KGHRI website, gone out and a vendor was selected. External service provider currently being hired to help drive communications for Research Institute and to shape the development of the KGHRI website.

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). ***Done***
- Research Institute: Where we are at (3 year summary): ***Underway***
- KGHRI branding and website development. ***Underway***
- Communication/marketing plan developed for KGHRI. ***Underway***
- Research showcase, cafes and other forums organized (annual event). ***Underway***

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

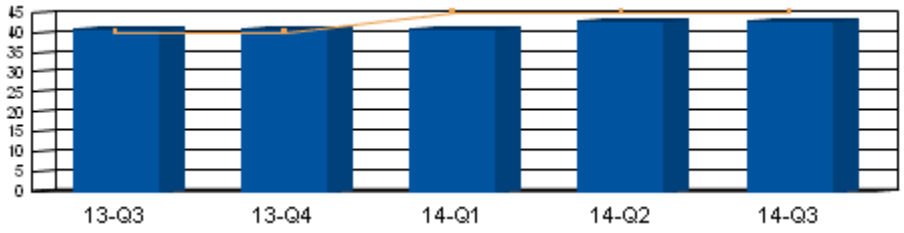
Kingston General Hospital

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

Interpretation - Patient And Business:

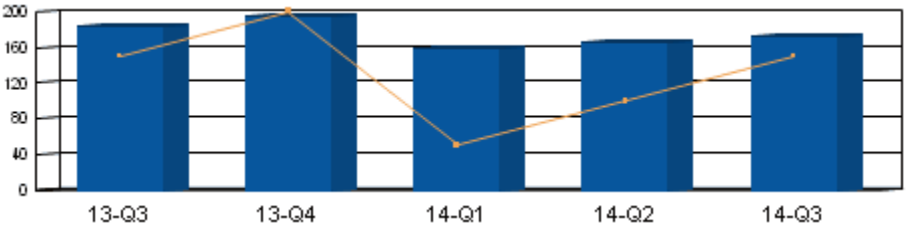
The KGH Research Annual Report was released in November 2013. The data for percent increase in research funds was recorded in Q2. Real F2013 data was used for reporting of F2014 data for this performance indicator since real figures for F2014 will not be available until September 2014. 95% of the data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

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

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-Q3	184	**150**
13-Q4	195	**200**
14-Q1	158	**50**
14-Q2	165	**100**
14-Q3	173	**150**

Interpretation - Patient And Business:

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

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

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

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

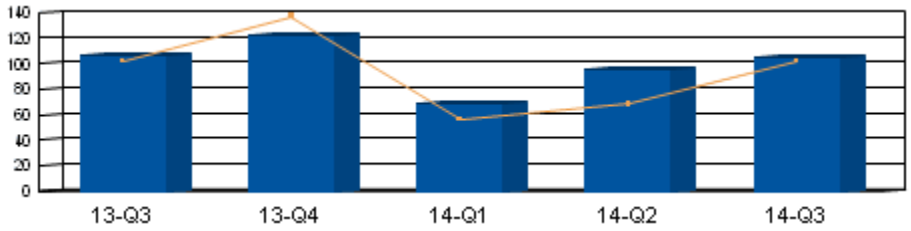
Kingston General Hospital

MS #05

Cultivate patient oriented research

Externally funded research at KGH has increased to 45%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
13-Q3	107	**102**
13-Q4	123	**137**
14-Q1	69	**56**
14-Q2	95	**68**
14-Q3	105	**102**

Interpretation - Patient And Business:

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

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

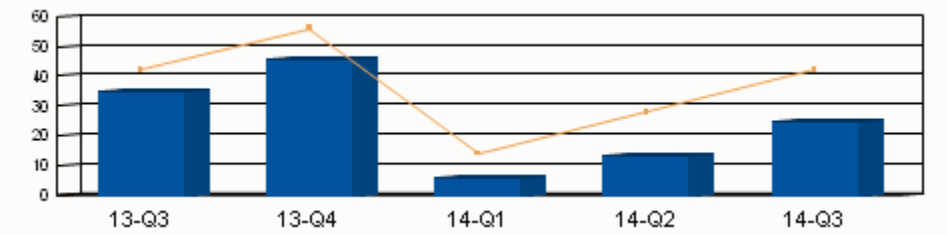
Definition: DATA: Veronica Harris-McAllister COMMENTS: Veronica Harris-McAllister SUPPORTING INDICATOR

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-Q3	35	**42**
13-Q4	46	**56**
14-Q1	6	**14**
14-Q2	13	**28**
14-Q3	25	**42**

Interpretation - Patient And Business:

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

Business Perspective: Based on the fiscal year to date, KGH is behind target by the end of the third quarter (Q3). As per our Agreement Affiliation with Queen's University, clinical trial contracts, agreements and grants are administered by the University Research Services' Contracts Office.

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

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?**

Of the three primary indicators 2 are yellow and one red (Patients waiting for transfer).

22 of the 24 indicators in MS #6 are G or Y= 92%

QBP targets have all been monitored by working groups and volumes followed closely. The QBPs COPD, CHF, Stroke and Vascular are difficult to regulate given their urgent/emergent procedures/care. Risks with over/under target exist and pose concern with uncertainty to impact to next years allocations. Hip and Knee have been challenging. A LHIN wide over allocation of knees and under allocation of hips has challenged all organizations to stop hip replacements and/or adjust volumes with reallocation of knees.

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)

Transfer patients: LHIN protocols for patriation/repatriation are evolving; Non urgent transport
Readmissions: connecting with Health Links

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?**

QBP: In preparation for the next fiscal year's two waves of new QBP, a QBP Steering Committee is being created.

Kingston General Hospital

MS #06

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

70	13-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
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	Y	Y	Y	R	↑
OR Cases (Inpatient and Outpatient)	G	G	G	G	G	↑
OR Hours (Inpatient & Outpatient)	G	G	G	G	G	↑
Stem Cell Transplants	G	G	G	G	G	↑
Percent of Discharge Summaries Sent to Primary Care Provider within 72 hours of Patient Discharge - (QIP)	R	R	R	R	R	↑
Percent of Contracted Volumes Achieved	G	G	G	G	G	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

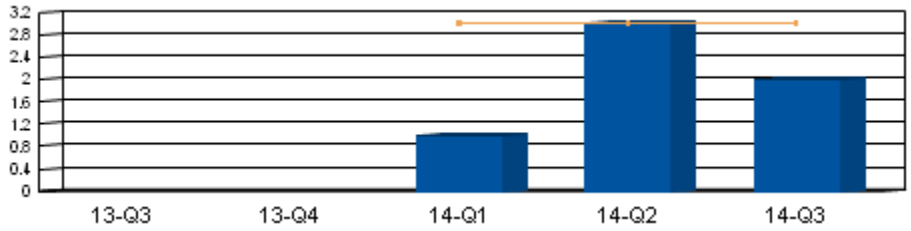
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

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

Indicator: A Protocol to Manage Each Improvement Priority is Adopted



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

Actions & Monitoring Underway to Improve Performance:

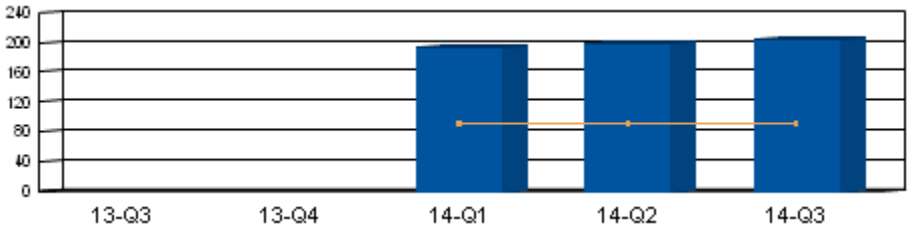
1. Patient Repatriation Transfer: Transfers to intra-LHIN hospitals requires frequent prompting to initiate activity. Upcoming transportation agreement is expected to help expedite and simplify transfers.
2. 30 day readmission rates: Data is in process of formatting to present to JQUIC.
3. QBP: Teams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

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

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-Q3		
13-Q4		
14-Q1	194	90
14-Q2	199	90
14-Q3	205	90

Interpretation - Patient And Business:

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

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 SUPPORTING INDICATOR

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

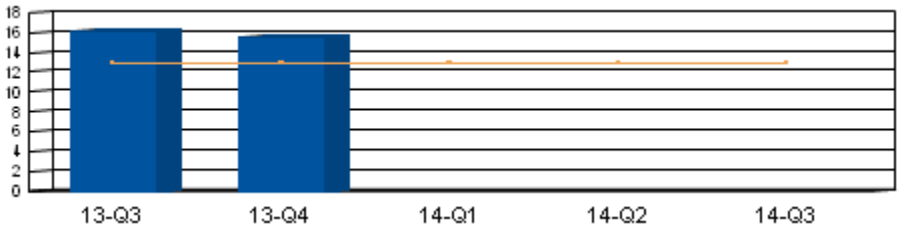
Kingston General Hospital

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-Q3	16.1	**12.9**
13-Q4	15.6	**12.9**
14-Q1		**12.9**
14-Q2		**12.9**
14-Q3		**12.9**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

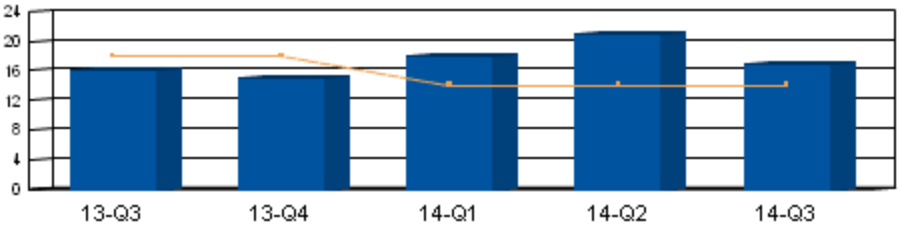
The data is supplied to KGH from the MOH and generally will be 3 quarters behind. The current rate of 15.6 is above the target of 12.9 but down from the previous quarter maintaining yellow status. An in-depth concurrent review took place in Q3 and triggered some focused follow-up by Departmental Quality 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 SUPPORTING INDICATOR

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-Q3	16	**18**
13-Q4	15	**18**
14-Q1	18	**14**
14-Q2	21	**14**
14-Q3	17	**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 QIP INDICATOR

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%

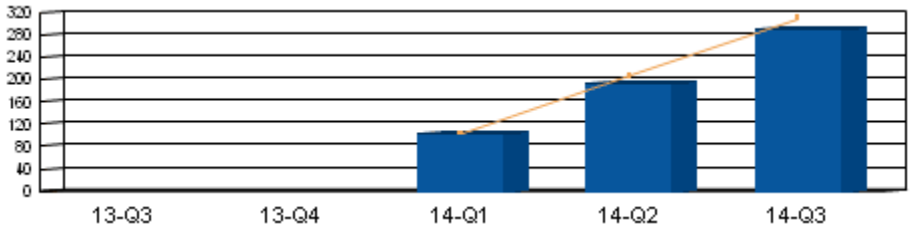
Kingston General Hospital

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-Q3		
13-Q4		
14-Q1	104	**103**
14-Q2	194	**206**
14-Q3	292	**309**

Interpretation - Patient And Business:

At the end of Q3 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

Actions & Monitoring Underway to Improve Performance:

At this stage of the QBP implementation it is challenging to confirm impact to the organization and clinical program/service. The volume calculation has been estimated and at this time (Q3) there are no 'prices' set for the clinical activity in question. A lead group has been established and in Q4 will undertake an assessment of the current state service provision relating to the service quality aspects identified to in the QBP guidance document.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt SUPPORTING INDICATOR

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 Perf. Corridor: Green 411 Yellow 370-410 Red <370 or >411

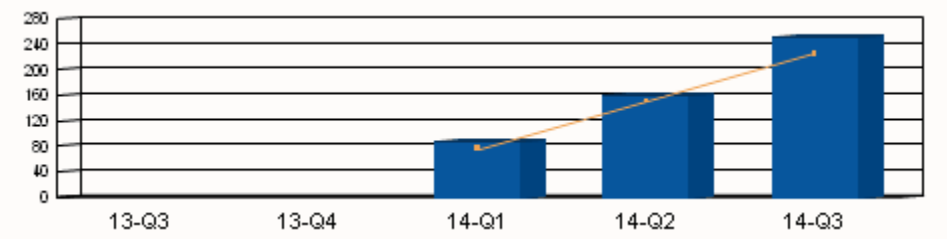
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

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

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



	Actual	Target
13-Q3		
13-Q4		
14-Q1	87	**75**
14-Q2	159	**150**
14-Q3	251	**225**

Interpretation - Patient And Business:

At the end of Q3 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.

Actions & Monitoring Underway to Improve Performance:

At this stage of the QBP implementation it is challenging to confirm impact to the organization and clinical program/service. The volume calculation has been estimated and at this time (Q3) there are no 'prices' set for the clinical activity in question. A lead group has been established and in Q4 will undertake an assessment of the current state service provision relating to the service quality aspects identified to in the QBP guidance document.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt SUPPORTING INDICATOR

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 Perf. Corridor: Green 301 Yellow 271-300 Red <271 or >301

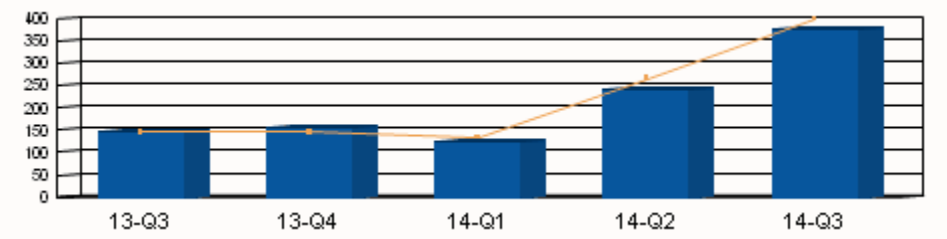
Kingston General Hospital

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-Q3	148	**145**
13-Q4	154	**145**
14-Q1	124	**133**
14-Q2	240	**266**
14-Q3	375	**399**

Interpretation - Patient And Business:

For Q3 YTD there have been 177 primary hip replacement surgeries completed of the new end of year target of 205 funded cases (11 additional funded cases provided by the SELHIN). Also there have been 198 primary knee replacements completed YTD of the end of year funded target of 338 cases.

Total hip/ knee revisions have a funded target volume of 112 cases with 106 completed YTD.

Actions & Monitoring Underway to Improve Performance:

SPA leadership in collaboration with the Division of Orthopedics have modified the OR orthopedic service schedule in Q4 to ensure that 70 primary knees will be completed in February with any outstanding case volumes to be addressed in March.

Monthly monitoring of the primary hip & knee volumes will continue with SPA leadership, Division Head of Orthopedics and the QBP working group.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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: Green 532 Yellow 479-531 Red <479 or >532

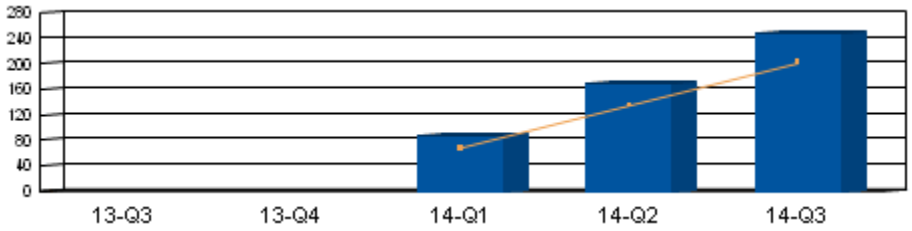
Kingston General Hospital

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-Q3		
13-Q4		
14-Q1	88	**67**
14-Q2	170	**134**
14-Q3	249	**201**

Interpretation - Patient And Business:

At the end of Q3 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.

Actions & Monitoring Underway to Improve Performance:

At this stage of the QBP implementation it is challenging to confirm impact to the organization and clinical program/service. The volume calculation has been estimated and at this time (Q3) there are no 'prices' set for the clinical activity in question. A lead group has been established and in Q4 will undertake an assessment of the current state service provision relating to the service quality aspects identified to in the QBP guidance document.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt SUPPORTING INDICATOR

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 Perf. Corridor: Green 268 Yellow 241-267 Red <241 or >268

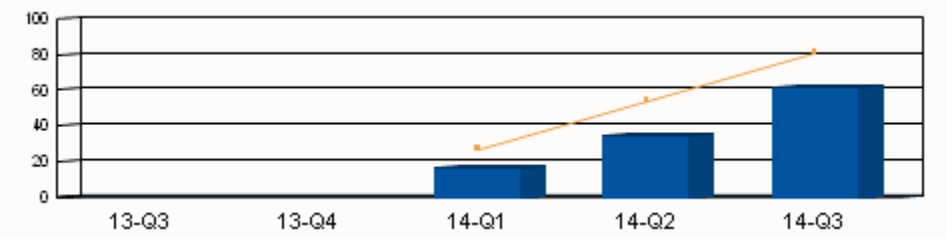
Kingston General Hospital

MS #06

Increase our focus on complex-acute and specialty care

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

Indicator: QBP (Quality Based Procedure) - Vascular



	Actual	Target
13-Q3		
13-Q4		
14-Q1	16	**27**
14-Q2	34	**54**
14-Q3	61	**81**

Interpretation - Patient And Business:

For Q3 there were 16 Acute inpatient Non-Cardiac Vascular Aortic Aneurysm (AA) completed. This has raised our volumes to 38 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 11 completed cases in this quarter with a total of 23 cases YTD. The current QBP year-end funded target for LEOD procedures is 46 cases.

Actions & Monitoring Underway to Improve Performance:

Monthly review of case volumes is occurring with the QBP working group and SPA leadership to ensure that cases are coded properly by the interprofessional team to achieve the funded targeted volumes.

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

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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 Perf. Corridor: Green 107 Yellow 96-106 Red <96 or >107

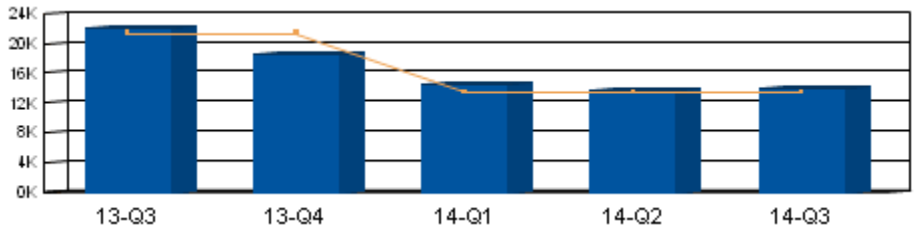
Kingston General Hospital

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-Q3	22,068	**21323**
13-Q4	18,613	**21323**
14-Q1	14,551	**13386**
14-Q2	13,787	**13386**
14-Q3	13,867	**13386**

Interpretation - Patient And Business:

For Q3 ambulatory activity continues to meet the new clinic target corridors. For this quarter there were 2,064 new patient visits, 3,166 lab visits, 427 telephone consultations, and 8,158 return follow-up care appointments.

Actions & Monitoring Underway to Improve Performance:

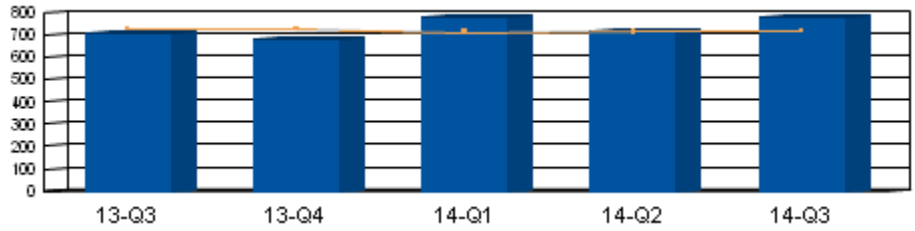
Discussions underway to review the relocation of the Cardiac Outpatient surgical services.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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-Q3	711	**725**
13-Q4	678	**725**
14-Q1	776	**712**
14-Q2	717	**713**
14-Q3	780	**718**

Interpretation - Patient And Business:

Cardiac Angiography volumes are above the target volumes in Q3. 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: Julie Caffin COMMENTS: Julie Caffin SUPPORTING INDICATOR

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

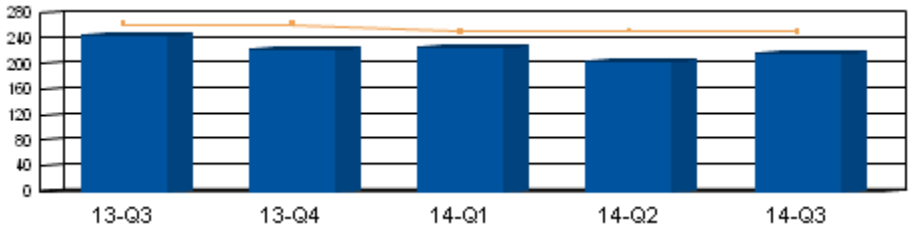
Kingston General Hospital

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-Q3	244	**262**
13-Q4	222	**262**
14-Q1	227	**250**
14-Q2	204	**251**
14-Q3	217	**250**

Interpretation - Patient And Business:

Cardiac Angioplasty volumes are below target in Q3. Angiography 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. Q3 rate is 28%. This would suggest that fewer angiograms result in angioplasty than has been the historical trend.

Definition: DATA: Julie Caffin COMMENTS: Julie Caffin SUPPORTING INDICATOR

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

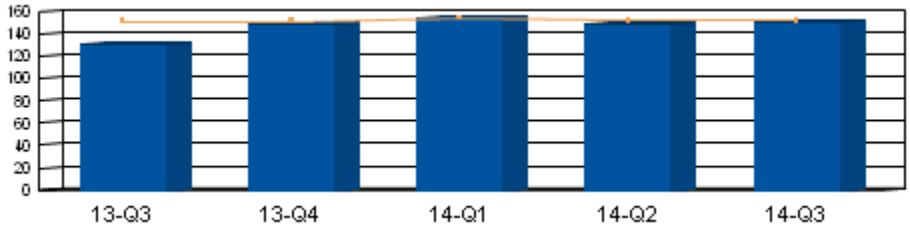
Kingston General Hospital

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

Interpretation - Patient And Business:

Cardiac surgery volumes are trending on target volumes at the end of Q3. 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. This has improved in Q3.

Actions & Monitoring Underway to Improve Performance:

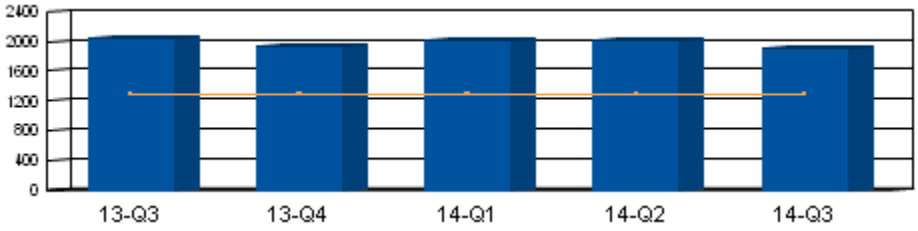
Cardiac surgical volumes are monitored weekly and monthly by the Cardiac and SPA Programs and the Wait Times Committee in order to achieve target volumes and wait times and to mitigate cancellations. Surgical volumes and wait times are monitored by the Cardiac Care Network (CCN) of Ontario. The monthly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

Definition: DATA: Julie Caffin COMMENTS: Julie Caffin SUPPORTING INDICATOR

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-Q3	2,033	**1286**
13-Q4	1,945	**1286**
14-Q1	2,005	**1287**
14-Q2	2,005	**1287**
14-Q3	1,912	**1287**

Interpretation - Patient And Business:

The CT hours always surpasses the target due to the fact that KGH operates 2 CT scanners but is only funded for 1. It is imperative that both scanners are operated so that the CT volume can be completed. The Emergency Department, the inpatient floors and various specialties such as Cancer Care all require quick access to the CT scanner.

Actions & Monitoring Underway to Improve Performance:

If KGH did not operate these hours the inpatient length of stay would increase, ER turnaround times would lengthen significantly.

Definition: DATA: Decision Support COMMENTS: Karen Pearson SUPPORTING INDICATOR

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

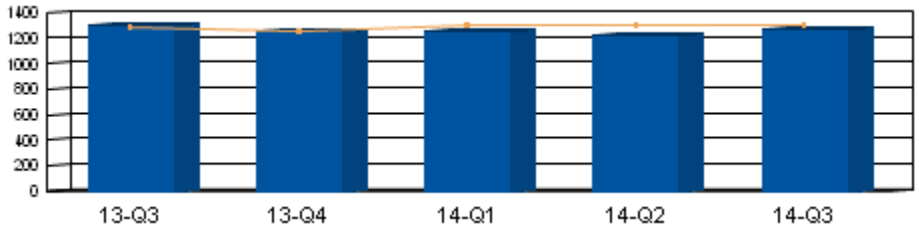
Kingston General Hospital

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-Q3	1,298	**1283**
13-Q4	1,257	**1250**
14-Q1	1,254	**1300**
14-Q2	1,221	**1300**
14-Q3	1,272	**1300**

Interpretation - Patient And Business:

The department has managed to nearly achieve the targeted hours every month. It has been challenging due to sick time issues. We have stretched available staffing over the required hours. However we have not been able to maintain the recommended safe levels of staffing of ensuring that there is 2 staff on per shift at a minimum during evenings and weekends. The Mon-Friday day shift staffing requires a minimum of 3 technologists staggered over 10 hours plus a senior technologist.

Adequate staffing ensures optimal operational hours which directly impacts the number of cases completed weekly and ultimately decreases the wait times of the patient.

Actions & Monitoring Underway to Improve Performance:

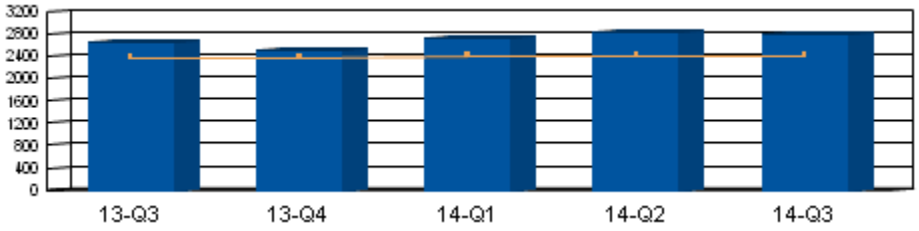
Recruit, train and retain adequate number of technologists to staff the magnet.

Definition: DATA: Decision Support COMMENTS: Karen Pearson SUPPORTING INDICATOR

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-Q3	2,657	**2370**
13-Q4	2,520	**2370**
14-Q1	2,736	**2416**
14-Q2	2,828	**2416**
14-Q3	2,804	**2416**

Interpretation - Patient And Business:

Emergency Department admitted patient volumes are above target by 388 admissions in Q3. Admitted patient volumes for the ED in Q3 are 147 admissions more than same period last year.
On average, 19% of all visits to the ED result in admission. Q2 result is 21%.

Actions & Monitoring Underway to Improve Performance:

The demand for the right inpatient beds is greater than bed capacity. Work is currently being done to redesign the bed map to align the right number of beds to programs. 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 SUPPORTING INDICATOR

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

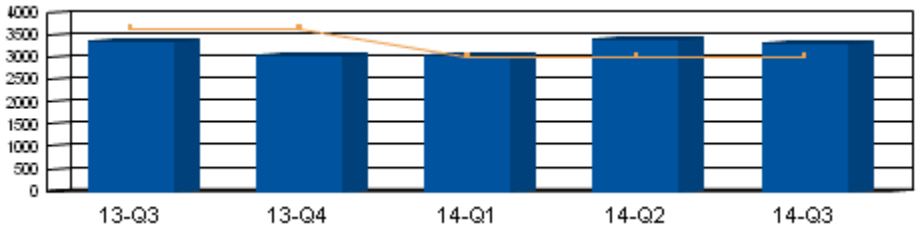
Kingston General Hospital

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-Q3	3,349	**3647**
13-Q4	3,028	**3647**
14-Q1	3,054	**3011**
14-Q2	3,411	**3011**
14-Q3	3,300	**3011**

Interpretation - Patient And Business:

The Emergency Department non-admitted, low acuity visits are above target volumes in Q3 and above target year to date.

Actions & Monitoring Underway to Improve Performance:

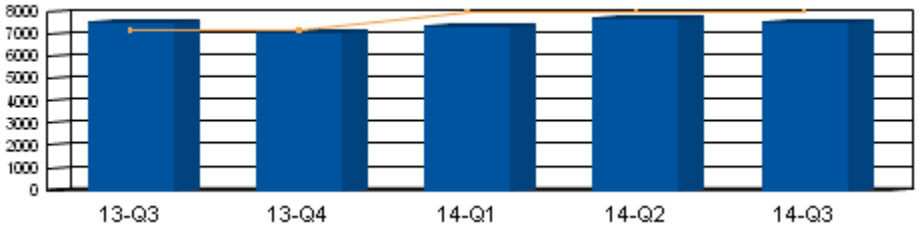
Volumes have decreased slightly in the category YTD over same period last year. Work is ongoing to profile the types of visits in this category. We continue to work with community partners to shift this lower acuity activity to somewhere other than the Emergency Department.

Definition: DATA: Decision Support COMMENTS: J. Caffin SUPPORTING INDICATOR

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-Q3	7,575	**7149**
13-Q4	7,045	**7149**
14-Q1	7,345	**7994**
14-Q2	7,755	**7994**
14-Q3	7,503	**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 Q3 this fiscal are in line with the same period last fiscal.

Actions & Monitoring Underway to Improve Performance:

This is the patient population we expect to see in the Emergency Department.

Definition: DATA: Decision Support COMMENTS: Julie Caffin SUPPORTING INDICATOR

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

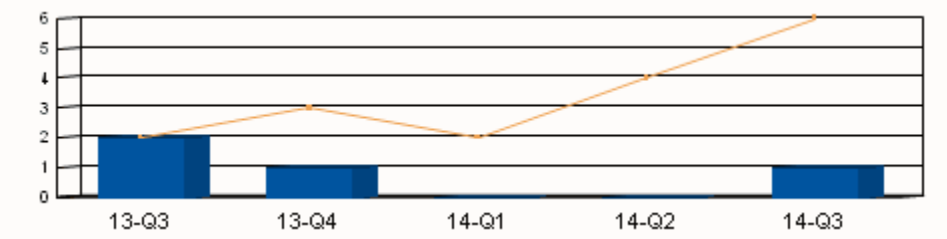
Kingston General Hospital

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-Q3	2	**2**
13-Q4	1	**3**
14-Q1	0	**2**
14-Q2	0	**4**
14-Q3	1	**6**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

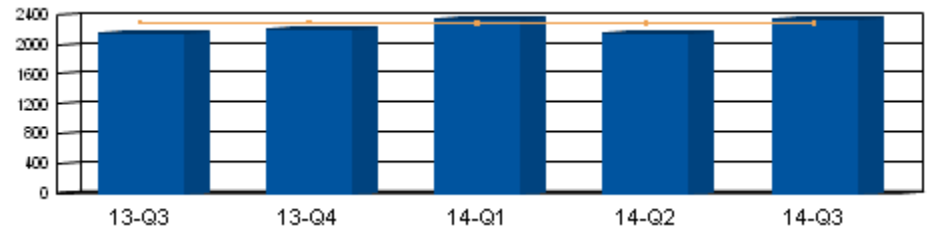
We continue to ready to respond appropriately to organ availability and support the transplantation for patients in our local region.

Definition: DATA: Lana Cassidy COMMENTS: Richard Jewitt SUPPORTING INDICATOR

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-Q3	2,159	**2286**
13-Q4	2,208	**2286**
14-Q1	2,329	**2282**
14-Q2	2,150	**2282**
14-Q3	2,328	**2282**

Interpretation - Patient And Business:

For Q3 this indicator continues to meet the green target corridor. In this quarter 37% of this volume was urgent/emergent cases and of the remaining 63% scheduled elective activity, one quarter was outpatient activity with the rest aligned to inpatient activity.

Actions & Monitoring Underway to Improve Performance:

The SPA program continues to proceed with the investment of the Perioperative Hybrid Nursing Training program with the second rotation of staff commencing in Q4.Inpatient and outpatient OR case volume activity is monitored by OR management and the Surgical Preoperative Anesthesia (SPA) program council.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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

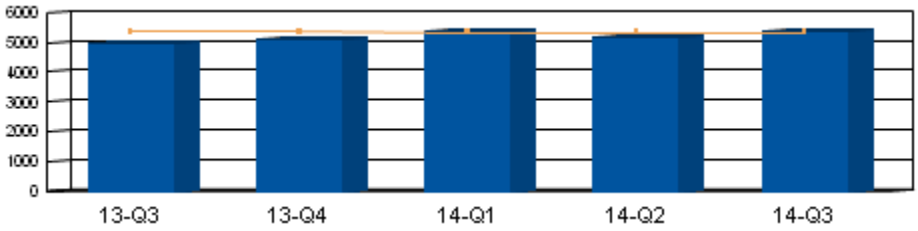
Kingston General Hospital

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-Q3	5,004	**5345**
13-Q4	5,114	**5345**
14-Q1	5,390	**5332**
14-Q2	5,173	**5332**
14-Q3	5,412	**5332**

Interpretation - Patient And Business:

For Q3 this indicator continues to meet the green target corridor due to ongoing Improvements with patient activity flow and the support of the Patient Assessment Care Unit/ Recovery Room resources.

Actions & Monitoring Underway to Improve Performance:

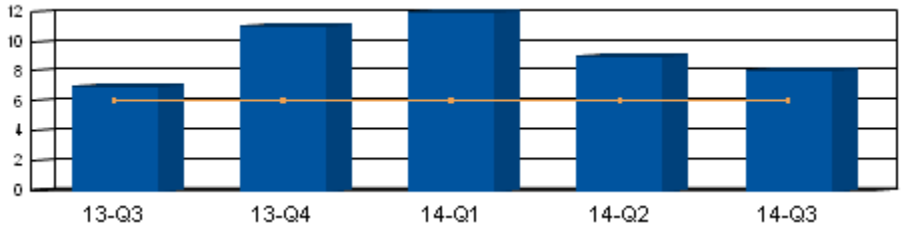
SPA program management and program council continue to monitor OR hours and inpatient/outpatient case volumes.

Definition: DATA: Decision Support COMMENTS: Kellie Kitchen SUPPORTING INDICATOR

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-Q3	7	**6**
13-Q4	11	**6**
14-Q1	12	**6**
14-Q2	9	**6**
14-Q3	8	**6**

Interpretation - Patient And Business:

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

Definition: DATA: Katelyn Balchin COMMENTS: Brenda Carter SUPPORTING INDICATOR

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

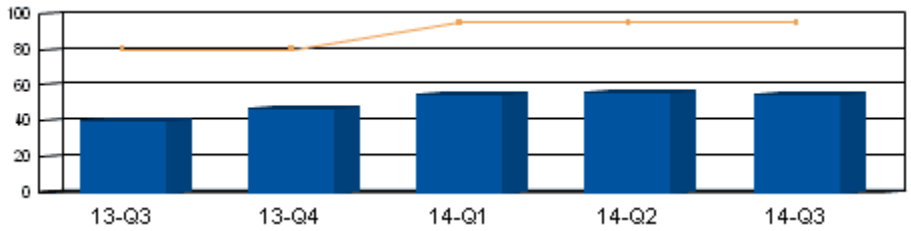
Kingston General Hospital

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

Interpretation - Patient And Business:

Third quarter results of 55% 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:

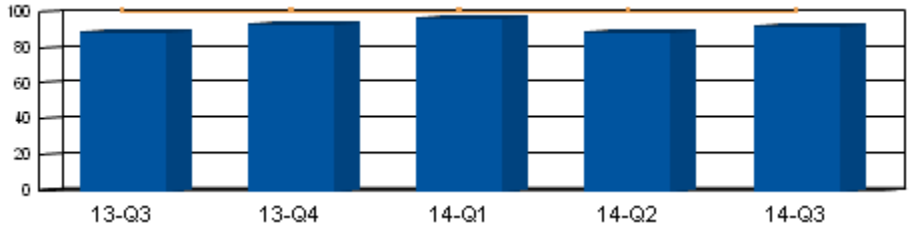
Data continues to be supplied to the Clinical Department's Quality Committees. The data drives down to the level of the individual physician. Re-engaging through JQUIC and MAC will be needed to spotlight the gap.

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

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-Q3	89	**100**
13-Q4	93	**100**
14-Q1	96	**100**
14-Q2	88	**100**
14-Q3	92	**100**

Interpretation - Patient And Business:

As of Q3, 2 of 25 contracted volume indicators had Red status. They are Adult General Surgery - Groin Hernia repair and Peds Plastic Surgery - Maxiofacial surgery.

Actions & Monitoring Underway to Improve Performance:

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

Definition: DATA: Decision Support COMMENTS: John Lott SUPPORTING INDICATOR

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?**
Activities to enhance engagement and enable the development of engagement actions plans are on track. Workshops were provided to leaders as part of the overall leadership development program, however, planning for automation for talent management and pilot of frontline leadership program were delayed. The rolling average for sick days increased to 11.78. New central CUPE collective agreement language related to restrictions of Attendance Management Programs, which was effective October may have been the catalyst for a 22-34% increase for the months of October, November, December over the previous year.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
Recognition program redesign briefing note was reviewed by the Operations Committee and input from various stakeholder group. Decision to continue with the current team awards and the 25/30/35/40/45 years milestone dinner and hold a seasonal tea in December. Corporate engagement surveys results posted on the intranet and individual team results shared. Ten – 1 hour survey results interpretation sessions for leaders were conducted. On-line tools were created and worksheets provided to leaders to facilitate action planning. Volunteer engagement survey was conducted in partnership with PAVR-O and there was a response rate of 54% (provincial average was 45%). Three sessions of Effective Team Leadership was conducted; planning underway to pilot with frontline leaders.

3. **Are we on track to meet the milestone by year end?**
Yes, we are on track to meeting the engagement initiative milestones, however we are under discussions with stakeholders and Information Systems regarding next steps on our leadership development program. We are not on track to meet the 10.5 average sick days for Q4.

4. **What new tactics are planned to ensure this milestone is met?**
Team awards and staff/volunteer years of service pins events to be held during the January KGH Community Celebration week. Continued workshops for leaders on engagement tag team training. Review of volunteer engagement results and action planning by tactical team. Meetings with Information Systems regarding automation of talent management system. An ad hoc group of the Operations Committee was struck to review current Attendance Management processes and make recommendations for future design.

Kingston General Hospital

MS #07

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

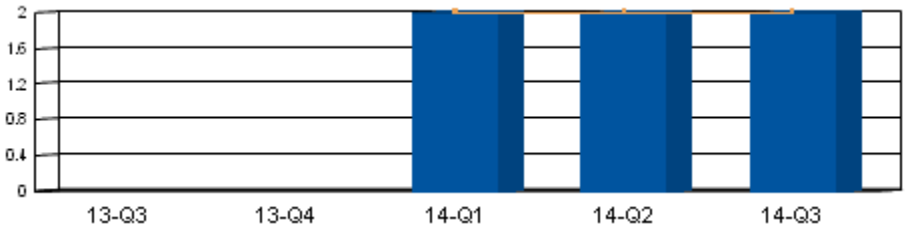
Kingston General Hospital

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

Interpretation - Patient And Business:

Corporate engagement survey results were shared and posted on the intranet. 72 leaders have attended the three 2 day sessions offered in Q3. Other training and supports includes communication workshops, one on one coaching, and support for roll out and team meetings. The Targeted Talent Solutions website/toolkit was launched to support leaders in roll out of action plans. 40 leaders registered for the online tool and 27 solutions had been chosen by Leaders to implement with their teams. Recognition events feedback received from staff and incorporated in recognition events including the long service dinner celebration, the Holiday Open House and meal on Christmas day for those working. Team awards were launched and the nomination process began in Q3. Wellness activities such as bringing back fitness classes occurred based on feedback.

Actions & Monitoring Underway to Improve Performance:

Leader engagement rollout and communications training final sessions will occur in Q4. 3 sessions of Effective Team Leadership series -introductory level 1 for 12 leaders were conducted and series level 2 has been developed. Roll out of leadership series is planned for front line leaders. Discussions with leaders regarding corporate actions will occur and performance agreement action plans are due by the end of Q4. Realignment of the Leadership and Learning portfolio with Healthy Workplace Services took place in Q3 and a new staff committee will be launched by end of fiscal year to become advisory on health, wellness, engagement and quality of worklife issues.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima STRATEGY INDICATOR

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

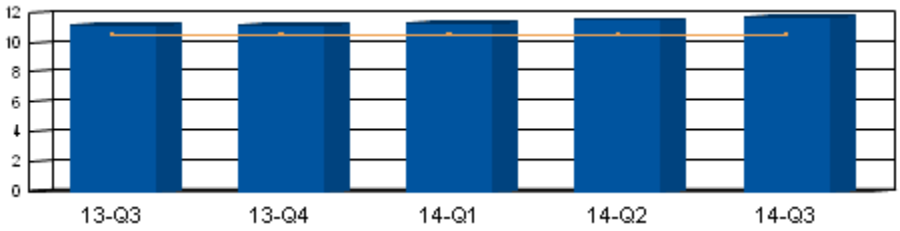
Kingston General Hospital

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-Q3	11.1	**10.5**
13-Q4	11.1	**10.5**
14-Q1	11.3	**10.5**
14-Q2	11.5	**10.5**
14-Q3	11.7	**10.5**

Interpretation - Patient And Business:

The rolling hospital average is 11.78 days as of the end of quarter. There are increases in absenteeism in particular in the CUPE bargaining unit which are trending upward. New central collective agreement language that came into effect in October saw 22-34% increases in the months of Oct, Nov, Dec over the previous year. The number of staff in the attendance program has decreased by 9% over last year, however, those with 1-5 incidents has increased.

Actions & Monitoring Underway to Improve Performance:

Wellness promotion activities continue such as fitness classes, smoking cessation and engagement. The attendance program design is under revision and additional resources are being considered in light of the new C.A. language.

Definition: DATA: Ruth Lachapelle COMMENTS: Micki Mulima SUPPORTING INDICATOR

The average sick days per eligible employee tracks all sick time of an employee on a twelve month rolling basis. Employees included are all active employees, eligible for paid sick time, as at the last day of the last calendar month of the twelve month period. Active employees include employees on leave of absence. It does not include employees who have terminated, retired or transferred to part-time positions during the twelve month period reported. The average is calculated based on total sick hours for all employees eligible for paid sick time divided by the total number of active employees, eligible for paid sick time as at the last day of the month. A day is based on 7.50 hours. The corporate goal is to reduce the average sick time to the Human Resources Benchmarking Network (HRBN) average for the healthcare sector in Ontario.

Target: Baseline 08/09: 14.03, Target 09/10: 12, Target 10/11: 11.5, Target 11/12: 10.5, Target 12/13: 10.5 Target 13/14: 10.5 Perf. Corridor: Red >12 Yellow 10.6-12 Green <=10.5

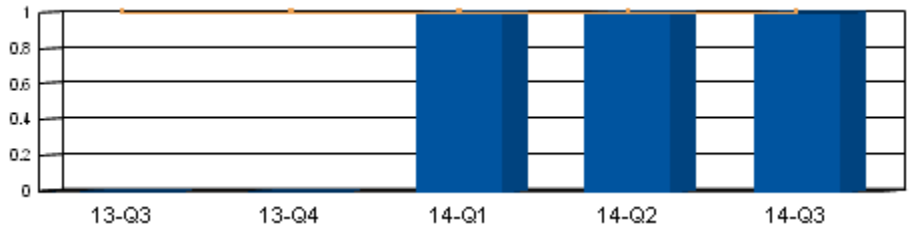
Kingston General Hospital

MS #07

People

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

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



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

Interpretation - Patient And Business:

Team level survey results have been shared at the team level and overall corporate results posted on the intranet. 98% of Leaders are now trained in interpreting results and roll out action planning for engagement. Supports and one on one coaching provided including a website for suggested actions and sharing success stories. Leaders are aware and have the tools to post their action plans to Directors folders and place in their performance agreements by the end of Q4.

Actions & Monitoring Underway to Improve Performance:

40 leaders have registered for the supporting engagement website and 27 solutions had been chosen by Leaders to facilitate action planning. Performance agreements review and checklist have been developed to further support leaders in action plan development. Regular communication for leaders regarding tools, tips, and requirements continue to keep target on track. Engagement tactics team continues meeting and nominated for Team Award based on the success of the survey roll out. "Plan the Plan" sessions for leaders will be offered to ensure we reach our milestone target in Q4.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima SUPPORTING INDICATOR

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

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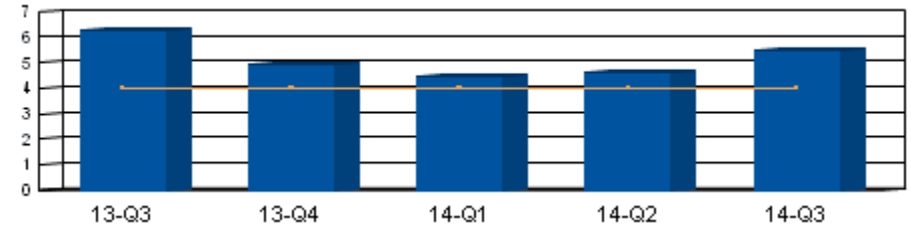
Indicator: Percent Sick Time Hours



	Actual	Target
13-Q3	6.3	4
13-Q4	4.9	4
14-Q1	4.5	4
14-Q2	4.6	4
14-Q3	5.5	4

Interpretation - Patient And Business:

Although sick time for this quarter is lower than last year, it has been trending upward in the two major employee groups; ONA and CUPE. New language in the CUPE Central Collective Agreement has coincided with a significant increase in sick time, the highest in several years. The number of incidents has not increased however, the length of time off and number of hours has increased.

Actions & Monitoring Underway to Improve Performance:

Wellness promotion activities continue such as fitness classes, smoking cessation and engagement. The attendance program design is under revision and additional resources are being considered in light of the new C.A. language.

Definition: DATA: Lana Cassidy COMMENTS: Micki Mulima SUPPORTING INDICATOR

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?**
Currently trending is yellow on the four priorities. The entire number of health and safety scorecard targets is in a positive yellow trend; concerns regarding fit testing compliance, completion of mandatory safety training and incidence of WSIB health care claims. Note: The hospital received a $460,000 NEER rebate from WSIB. Improvement of leaders in responding to identified hazards and management inspection program. However, leaders are not completing the incident investigations in the required timeframes.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
Safe reporting tool reconfigured to improve data collection in a number of areas and leaders follow-up on incident investigations. Analysis of NSIs identified new factors contributing to trend. Additional education on the Nexiva IV was provided. Change in policy designated Security to assist patient in/out of cars instead of porters; training was delivered to Security and video filmed to demonstrate how to safely assist patients in/out of cars. The purchase of new transfer boards was finalized. Review of current practices related to fit mask testing.

3. **Are we on track to meet the milestone by year end?**
Yes, we are on track to meet the milestone at end of Q4.

4. **What new tactics are planned to ensure this milestone is met?**
Needle safety training to be rolled-out. New Safety Eclipse Arterial syringe to be implemented. Roll-out of new transfer boards and continued data analysis to assist managers in hazard recognition and control. Areas of non-compliance for mandatory training have been identified and follow-up with applicable management to enable staff time to complete the required training. Continued follow-up with leaders regarding accountability to meet designated timelines

Kingston General Hospital

MS #08

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

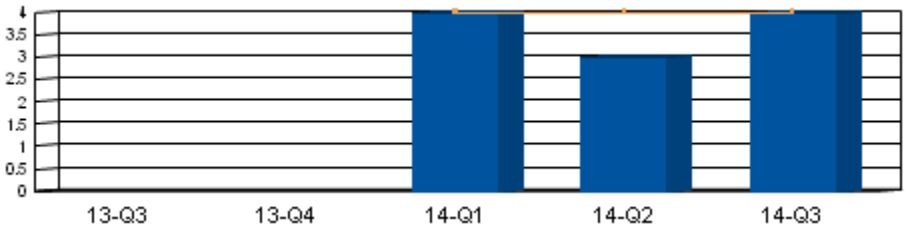
Kingston General Hospital

MS #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-Q3		
13-Q4		
14-Q1	4	4
14-Q2	3	4
14-Q3	4	4

Interpretation - Patient And Business:

Tactics for reducing musculoskeletal injuries (MSI), Needlesticks, violence related injuries and staff falls are initiated.
MSI- 3 MSIs that resulted in lost time from work occurred in Medicine (2) and Kidd 3 (1). .
Needlesticks- Needle Safety Training for clinical staff to address the top sources of harm is now in draft with target roll-out date of end of Q4.
Violence Related Injuries- value stream mapping for BCA finalized; Behavioural Crisis Alert incorporated as part of the ER patient transfer checklist
Falls- The tactical team has linked in with the corporate patient falls team and work is continuing.

Actions & Monitoring Underway to Improve Performance:

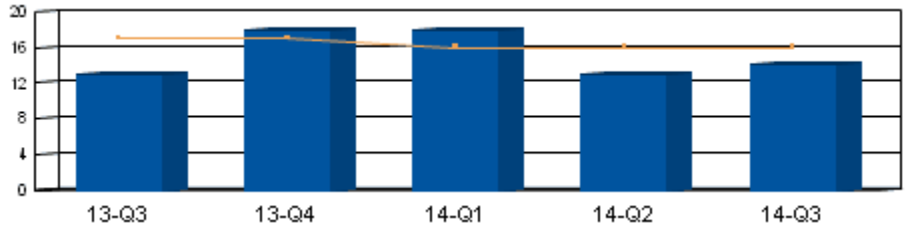
Needlesticks remains above target. We are converting to safety engineered ABG syringe in Q4, and currently assessing opportunity to convert from syringes to pens for administration of insulin for improved safety. New version of Safe Reporting has been configured to improve data collected on needlestick injuries and has resulted in modification to the Management form to facilitate improved investigation and management of NSIs.

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan STRATEGY INDICATOR

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

Interpretation - Patient And Business:

6 indicators that are not reaching/approaching target include: Incidence of Needlestick injuries, Lost time severity rate, completion of incident investigations, Respirator Fit Testing compliance, Completion of mandatory safety training, and Incidence of WSIB health care claims

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan SUPPORTING INDICATOR

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?

24/24 Improvement Priorities are actively using continuous improvement principles & PDSA improvement cycles. All are at various stages of team development.

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

During Q3 our focus was on:

- Define Process for Decision to Admit - in progress
- Bed Allocation - process for accurate and timely data to bed allocators - In sustainability mode
- Bed Allocation - Define a standard beds status notification process - in progress
- Determine a process for handover from ED to inpatient unit - In sustainability mode
- Design process for accurate on call details - in progress
- Standardize the Process for Discharge Across KGH from Discharge Order to Patient Departure (in progress)
- Standardize the Process for Discharge Prediction with Purpose Across KGH (in progress)
- Consults - Define process for CCAC, SW, OT, PT, SLP, Transfer Service Consults (in progress)

Focus for Q4 will be:

- Improve the process for Emergent OR bookings
- Consults - Determine standard process for utilizing data between Consult and HRF
- Implement a process to better collaborate with External Partners to plan for Patient Discharge

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?

- Patient and Family Centred Care standards
- Engagement improvement cycles
- Through regular Patient Flow Task Force meetings
    - Track resources participating on each PDSA to assist with prioritization
    - Maintain bi-weekly updates on all PDSAs
    - Develop a plan for “refresher” training for leaders and staff as required

Kingston General Hospital

MS #09

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

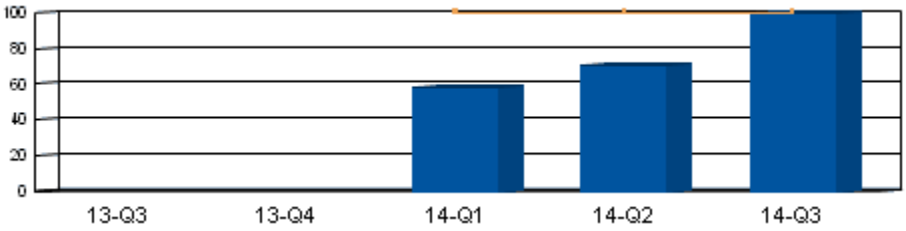
Kingston General Hospital

MS #09

Processes

Adoption of continuous improvement principles is increased

Indicator: Number of Improvement Priorities Using PDSA Improvement Cycles



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

Interpretation - Patient And Business:

24 out of 24 Improvement Priorities (100%) are actively using continuous improvement principles and PDSA improvement cycles. This approach has not only been well received but proven to be very effective in identifying opportunities for improvement from a quality, flow and general efficiency perspective.

Definition: Data: Decision Support COMMENTS: John Lott STRATEGY INDICATOR

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

Red

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?**
   As previously reported, we made our Stage 1 submission at the end of Fiscal 2013, and the Ministry has requested additional information related to surgical capacity and plans (Surgical Plan) for HDH and KGH. Although this work is in progress, the Surgical Plan will at best be submitted in March to the Ministry, and therefore we will not be awarded Stage 2 by March 31, 2014 as the Ministry will take time to review and consider the detail.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
   In December 2013, Agnew Peckham was contracted to create the Surgical Plan by HDH and KGH. Work began in December and is continuing in Q4 to complete the Surgical Plan. Carpet removal is at 92%, and expect to be done by March 31, 2014. The report on parking opportunities for improvement was presented in January, 2014 (Q4).

3. **Are we on track to meet the milestone by year end?**
   It is our estimate that the Surgical Report will be completed by March 31, 2014. Adding in time for Ministry review, it is not possible that we will have Stage 2 approval before the end of the fiscal year. We are now working toward obtaining approval for Stage 2 in the first half of Fiscal 2015.

4. **What new tactics are planned to ensure this milestone is met?**
   We are working with HDH to finalize the Surgical Plan and engaging LHIN and Ministry in the process to enhance the chances the report will meet their needs.

Kingston General Hospital

MS #10

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

Indicates improving performance to target over the past 5 quarters 

Indicates worsening performance to target over the past 5 quarters 

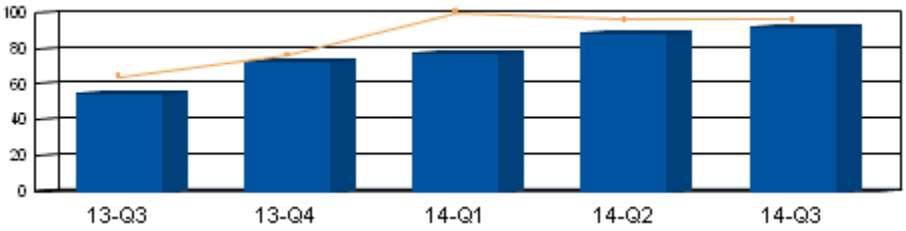
Kingston General Hospital

MS #10

Facilities

Phase 2 redevelopment is advanced

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
13-Q3	55.00	**64**
13-Q4	73.00	**76**
14-Q1	76.75	**100**
14-Q2	88.60	**96**
14-Q3	92.00	**96**

Interpretation - Patient And Business:

As noted previously in the Q2 report, the project fell short of the projected 96% completion to 88.6% due to the flooring contractor strike. The following areas remain to be completed in Q4:
- FAPC 5
- Davies 5
- Kidd 2 (corridor on a change order)
- Victory 2 (on a change order)
- Dietary 2 SDA

Definition: DATA: Allan McLuskie COMMENTS: Allan McLuskie SUPPORTING INDICATOR

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

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

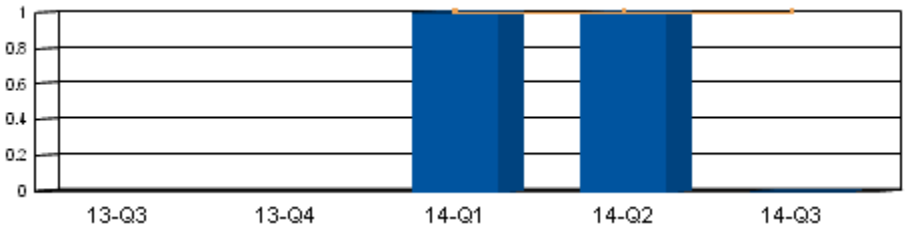
Kingston General Hospital

MS #10

Facilities

Phase 2 redevelopment functional programming commences

Indicator: Stage 2 Approval Status



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

Interpretation - Patient And Business:

Agnew Peckham has been facilitating discussions (9-13 Jan) between KGH/HDH to come to a consensus about OR configuration in Kingston. The immediate objective is: To calculate the number of ORs required at KGH and HDH to facilitate a timely submission and approval by the MOHLTC for facility redevelopment. Next steps:
1. CEOs/COOs meet to determine the scenarios and whether bariatric surgery will be specifically articulated as one of the flexibility factors.
2. Schedule and meet with the LHIN to discuss the approach and assumptions/parameters and if necessary:
- obtain their perspective on the need to explore different service delivery model scenarios
- specifically articulate bariatrics in the flexibility factor
3. Obtain outstanding data and information (i.e., average surgical time by specialty at HDH, turnover time at each organization)

Definition: DATA: Allan McLuskie COMMENTS: Allan McLuskie STRATEGY INDICATOR

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

Yellow

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?**
   Progress continues to be made on all five projects. Lab Order Entry and Automated Drug Cabinets have been impacted by the vacancy in the Project Management Office, but overall time lines are expected to be close to plan. Staff Scheduling Steering Committee has approved additional time to confirm the additional cost and value associated with the project. See summary below of projects.
2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
   The last vacancy in the Project Management Office has been filled with a start date of February 10th.
3. **Are we on track to meet the milestone by year end?**
   The project manager vacancy will be filled effective February. His/her primary focus will be to determine an effective approach to streamline the next phases of the automated drug cabinet and Lab order entry projects to keep on track.
4. **What new tactics are planned to ensure this milestone is met?**
   N/A

EDIS Computerized Provider Order Entry The EDIS Steering Committee approved the project scope in November. Project tasks are behind due to difficulty securing resources to design the orders and the medication order catalogue. We are awaiting a quote from QCPR to move forward to build the inbound interface for lab and DI orders. A plan is in place to secure the needed resources.

Automated Drug Cabinets Installs on K5; C10 and K6 completed during October and November as per plan. Project Manager vacancy has delayed future planning. We were ahead of schedule with the implementation and now may end up back on the original schedule for end of Q1 F2015.

Lab Order Entry A successful pilot of a process improvement cycle was completed in November as planned. Rolling out this new process in the cancer centre will result in process efficiencies in the CCSEO and standardize across outpatient areas. The vacancy in the project manager role has delayed planning for the Armstrong clinic rollout, which will be planned in Feb.

Staff Scheduling & Time Capture Project During the design phase of the project, the product vendor worked with our team to determine a detailed future-state for scheduling and time capture. This process resulted in projected increased implementation costs from this vendor. Due to this unexpected increase in both costs and timelines, the design is not yet completed and thereby delayed.

Regional IT System Progress Selection of firm to develop the RFP for a common Hospital Information System (HIS) has been awarded. Firm has developed framework for requirement gathering and started to identify timeline and resources required to participate in the process.

Kingston General Hospital

MS #11

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

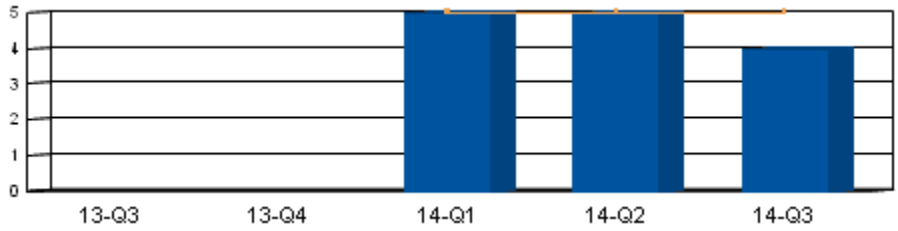
Kingston General Hospital

MS #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-Q3		
13-Q4		
14-Q1	5	5
14-Q2	5	5
14-Q3	4	5

Interpretation - Patient And Business:

Progress continues to be made on all five projects. Lab Order Entry and Automated Drug Cabinets will be impacted during Q4 by the vacancy in the Project Management Office. Staff Scheduling has approved additional time to confirm the additional cost and value associated with the project.

Actions & Monitoring Underway to Improve Performance:

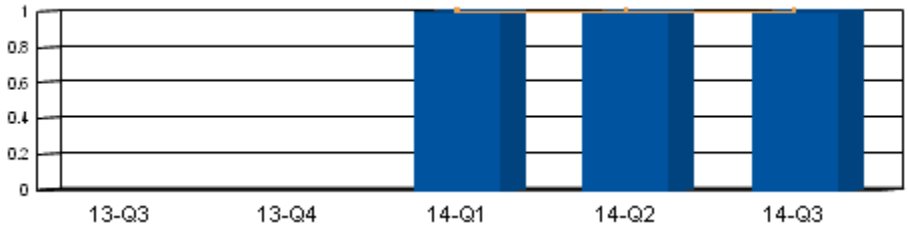
The last vacancy in the Project Management Office has been filled with a start date of February 10th.

Definition: DATA: Troy Jones COMMENTS: Troy Jones STRATEGY INDICATOR

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

Interpretation - Patient And Business:

During the design phase of the project, the product vendor worked with our team to determine a detailed future-state for scheduling and time capture. This process resulted in projected increased implementation costs from this vendor. Due to this unexpected increase in both costs and timelines, the design is not yet completed and thereby delayed.

Actions & Monitoring Underway to Improve Performance:

In order to ensure that the added costs provide value-add to the organization, the project team is extending the design phase to include a detailed evaluation of design solution (and costs). If the value-add is not as predicted in the business case the project team will have alternate paths available to pursue.

Definition: DATA: Marion MacInnis COMMENTS: Marion MacInnis SUPPORTING INDICATOR

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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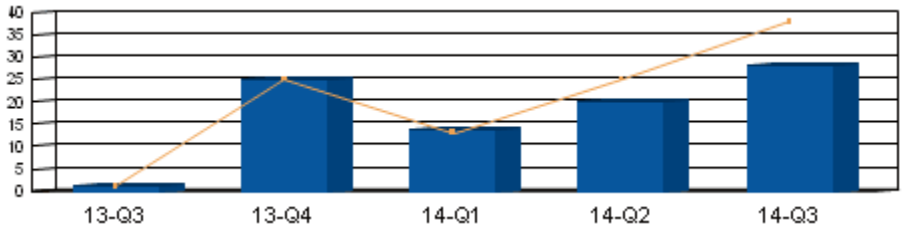
Kingston General Hospital

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-Q3	1	**1**
13-Q4	25	**25**
14-Q1	14	**13**
14-Q2	20	**25**
14-Q3	28	**38**

Interpretation - Patient And Business:

Installs on K5; C10 and K6 completed during October and November as per plan. Project Manager vacancy has delayed future planning. Vacancy may result in implementation delays.

Actions & Monitoring Underway to Improve Performance:

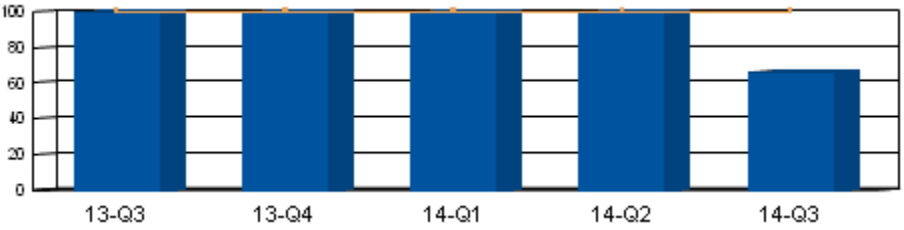
Project Management vacancy has been filled with a start date of February 10th. The new project manager will focus on determining if the current delay will impact the overall project timeline.

Definition: DATA: Alan Smith COMMENTS: Alan Smith SUPPORTING INDICATOR

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-Q3	100	**100**
13-Q4	100	**100**
14-Q1	100	**100**
14-Q2	100	**100**
14-Q3	66	**100**

Interpretation - Patient And Business:

A successful pilot of a process improvement cycle was completed in November as planned. Rolling out this new process in the cancer centre will result in process efficiencies in the CCSEO and standardize across outpatient areas. A vacancy in the project manager role has delayed planning for the Armstrong clinic rollout.

Actions & Monitoring Underway to Improve Performance:

The project manager vacancy will be filled effective February. His/her primary focus will be to determine an effective approach to streamline the next phase of the project to get back on track to complete the Armstrong clinics.

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

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

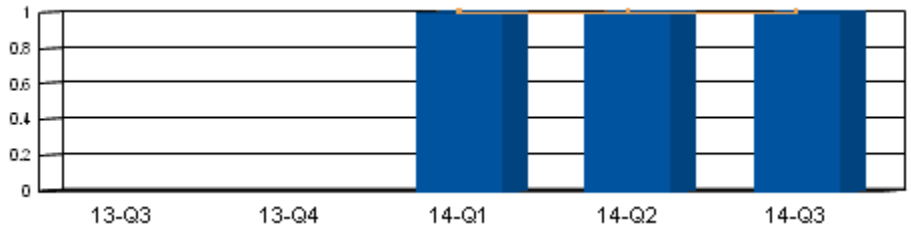
Kingston General Hospital

MS #11

Technology

Strategic technology projects are completed on time and on budget

Indicator: Phase 3 of EDIS is Implemented



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

Interpretation - Patient And Business:

The EDIS Steering Committee approved the project scope in November. Project tasks are behind due to difficulty securing resources to design the orders and the medication order catalogue.
We are awaiting a quote from QCPR to move forward to build the inbound interface for lab and DI orders.
A plan is in place to secure the needed resources.

Actions & Monitoring Underway to Improve Performance:

The EDIS Steering Committee members understand that the resources previously agreed to are required to deliver on the project plan and that the resource intensity and the expertise required will vary. The SC members have confirmed their commitment to support scheduling resources required to complete the project plan.

Definition: COMMENTS: Julie Caffin SUPPORTING INDICATOR

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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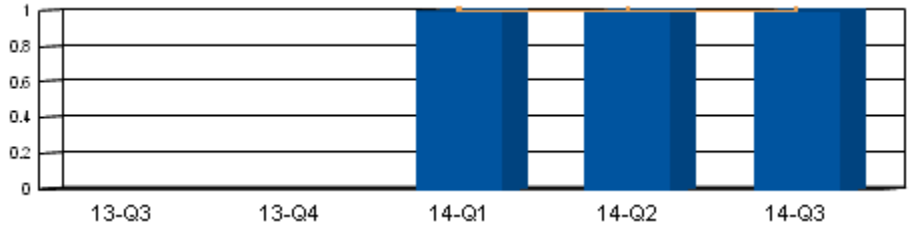
Indicator: Participation in a Regional Plan for IT Systems



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

Interpretation - Patient And Business:

Selection of firm to develop the RFP for a common Hospital Information System (HIS) has been awarded. Firm has developed framework for requirement gathering and started to identify timeline and resources required to participate in the process.

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 SUPPORTING INDICATOR

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 Q3, we had a positive variance to plan of $2.8 million. Variances previously reported continued through Q3 and are the ongoing subject of reviews and analysis so that we can address in the budget process. The positive results are primarily due to vacancies in several areas of the hospital, but this impact is slowing as we have had some success in filling positions.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
   Continue work on our 2014/15 budget and exploring in detail our financial variances and plans has continued through Q3. This activity will help us continue to address the current variances and pressures noted above.

3. **Are we on track to meet the milestone by year end?**
   Yes, we continue to project 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-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
Finances	Financial health is sustained	Hospital Operations Actual vs Plan Variance ($000's)	G	G	R	G	G	↑
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	G	G	Y	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 ↓

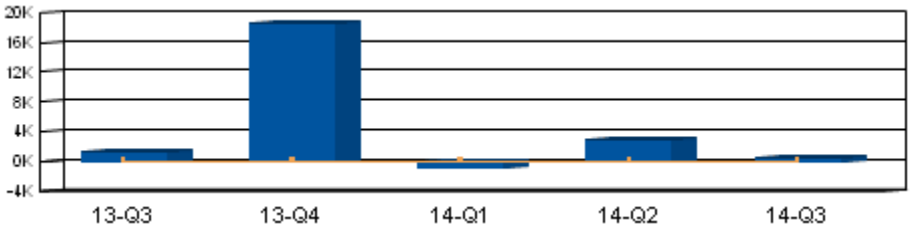
Kingston General Hospital

MS #12

Finances

Financial health is sustained

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



	Actual	Target
13-Q3	1,411	**0**
13-Q4	18,555	**0**
14-Q1	-748	**0**
14-Q2	3,019	**0**
14-Q3	526	**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:

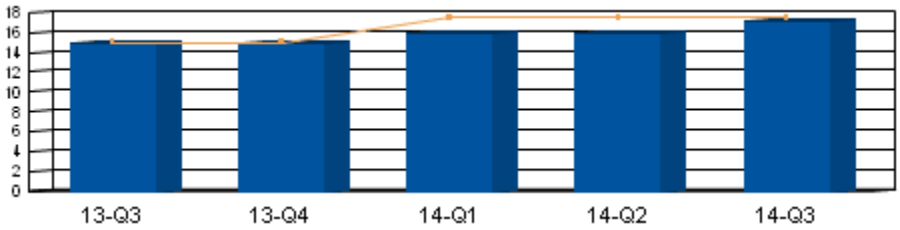
At the end of Q3, the total margin is within the Ministry acceptable range (0 - 3%). The operating results for this 9 month period are favourable to budget as reflected in the Hospital Operations Actual vs. Plan Variance indicator. At this time, the hospital is projecting a favourable operating position from 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 STRATEGY INDICATOR

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-Q3	15	**15.0**
13-Q4	15	**15.0**
14-Q1	16	**17.5**
14-Q2	16	**17.5**
14-Q3	17	**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. At the end of Q3, this capacity totals $17.1 million.

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

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

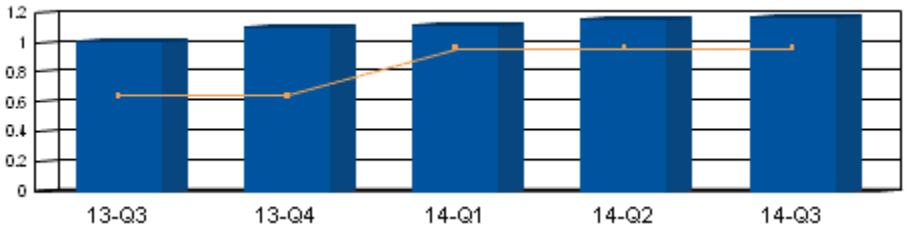
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Current Ratio



	Actual	Target
13-Q3	1.01	**0.64**
13-Q4	1.10	**0.64**
14-Q1	1.12	**0.96**
14-Q2	1.16	**0.96**
14-Q3	1.17	**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 Q3 has improved from the prior year ending position due mainly to the recognition of prior year deferred revenues and one-time Ministry funding and timing differences on payment processing.

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

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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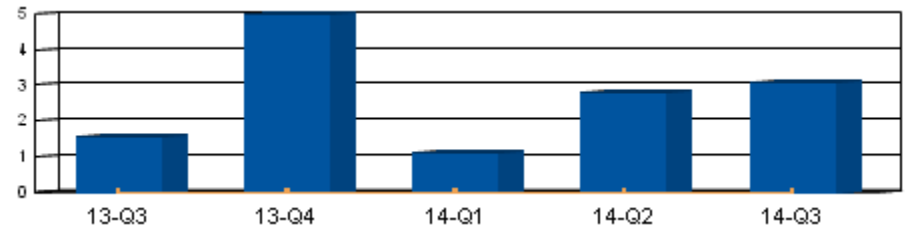
Indicator: Total Margin



	Actual	Target
13-Q3	1.55	**0**
13-Q4	4.97	**0**
14-Q1	1.08	**0**
14-Q2	2.78	**0**
14-Q3	3.09	**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 Q3, the total margin is within the Ministry acceptable range (0 - 3%). The operating results for this 9 month period are favourable to budget as reflected in the Hospital Operations Actual vs. Plan Variance indicator. At this time, the hospital is projecting a favourable operating position from 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 SUPPORTING INDICATOR

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

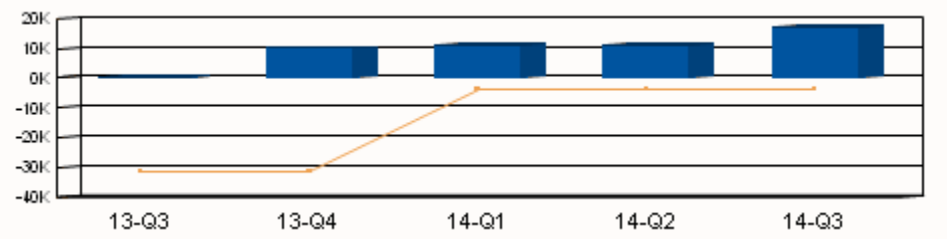
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Working Capital ($000's)



	Actual	Target
13-Q3	610	**-31500**
13-Q4	10,071	**-31500**
14-Q1	11,321	**-3706**
14-Q2	11,312	**-3706**
14-Q3	17,216	**-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 current ratio as at the end of Q3 has improved from the prior year ending position due mainly to the recognition of prior year deferred revenues and one-time Ministry funding and timing differences on payment processing.

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

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 workplan was developed over Q1 and 2 for understanding communication needs and how communications training would be addressed for the KGH leadership group. The plan reflects specific communication skills development with emphasis on leader/manager communication with direct care and service providers. With completion of the curriculum design, three training sessions were held in October, November and December, and resulted in 91% (n=92) of leaders having completed communications training. Feedback from attendees, while informal, was very positive.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** The curriculum for the communication skills workshop was completed and 3 workshops were held. There was also successful recruitment of Theresa MacBeth to the new Director, Strategy Management and Communications position.

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?** A fourth training session is scheduled to take place in Q4 to enable access of all leaders to the skills education. Executives and project leaders are being deliberate in reinforcing awareness and utilization of the tools provided in the workshops. The communications team, under the leadership of the new Director, Strategy Management and Communications, is exploring a customer service model that will ensure alignment and access of all programs and departments to a key contact who can then enable access to resources as needed and as expert resource in advancing use of communication skills.

Kingston General Hospital

MS #13

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

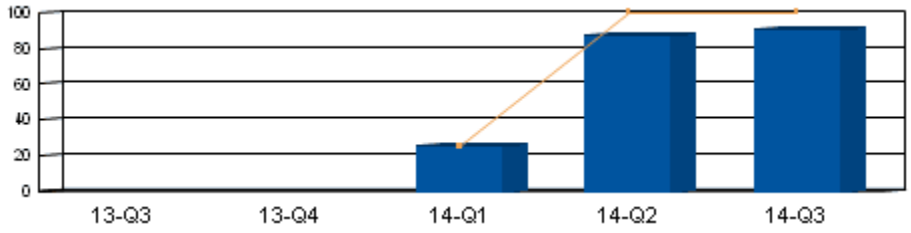
Kingston General Hospital

MS #13

Communication

KGH communication standards are consistently implemented across the organization

Indicator: Percent of Leaders Who Complete Communication Training



	Actual	Target
13-Q3		
13-Q4		
14-Q1	25	25
14-Q2	87	100
14-Q3	91	100

Interpretation - Patient And Business:

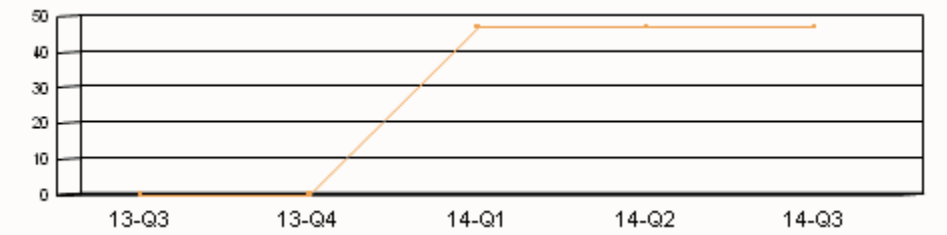
A plan and the framework for how we will address communications training for the KGH leadership group was developed and we identified specific communications skill-development needs by conducting a 'Think Tank' on high-performance leadership communication in Q1. In Q2, we continued to seek input from 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, and we finalized a curriculum for our leadership communication training session. Three training sessions were held in October, November and December, 2013. A fourth training session is planned for January 2014. As of Q3, 91 per cent of leaders have completed or registered to complete communications training.

Definition: Data: Theresa MacBeth COMMENTS: Theresa MacBeth STRATEGY INDICATOR

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%

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-Q3		0
13-Q4		0
14-Q1		47
14-Q2		47
14-Q3		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 as worded are not available. We have subsequently chosen to measure staff satisfaction with communications at KGH through the 2013 Employee and Physician Engagement Survey. A question to measure employee satisfaction with communications was included on the Employee Engagement Survey. The question was designed to measure the effectiveness of our current communications vehicles and employee preferences. Information gathered from these responses will inform the design of our internal communications programs.

Definition: DATA: Theresa MacBeth COMMENTS: Theresa MacBeth SUPPORTING INDICATOR

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

Target: 12/13 Target: 47%, 13/14 Target: 47% Perf. Corridor Red <37% Yellow 37%- 46% Green >=47%

Kingston General Hospital

2014 Strategy Report

			13-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
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	G	G	G	
	The top sources of preventable harm to patients are addressed	Number of Preventable Harm to Patient Indicators Met	N/A	N/A	Y	Y	R	↓
	The top sources of GRIDLOCK are addressed.	Percent of Recommendations Completed as per Incident Review Triggered by Code GRIDLOCK - (QIP)	N/A	N/A	Y	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	G	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	R	Y	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	Y	Y	G	
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	G	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	G	Y	G	↑
Processes	Adoption of continuous improvement principles is increased	Number of Improvement Priorities Using PDSA Improvement Cycles	N/A	N/A	G	G	G	↑
Facilities	Phase 2 redevelopment functional programming commences	Stage 2 Approval Status	N/A	N/A	Y	Y	R	↓
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	G	G	Y	↓
Finances	Financial health is sustained	Hospital Operations Actual vs Plan Variance ($000's)	G	G	R	G	G	↑
Communication	KGH communication standards are consistently implemented across the organization	Percent of Leaders Who Complete Communication Training	N/A	N/A	G	G	G	↑

↑ Indicates improving performance to target over the past 5 quarters

↓ Indicates worsening performance to target over the past 5 quarters

Kingston General Hospital

2014 QIP

			13-Q3	13-Q4	14-Q1	14-Q2	14-Q3	
Transform the patient experience through a relentless focus on quality, safety and service	KGH Patient Experience Advisors are trained and participate in the achievement of all improvement priorities	Overall Acute Care Patient Satisfaction (%) - (QIP)	G	G	G	G	N/A	↑
		Overall Emergency Care Patient Satisfaction (%) - (QIP)	G	G	G	G	N/A	↑
	The top sources of preventable harm to patients are addressed	Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)	N/A	N/A	Y	Y	R	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	R	R	R	G	G	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days - (QIP)	Y	G	Y	Y	G	↑
		Hand Hygiene Compliance - (QIP)	G	Y	Y	R	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	N/A	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	Y	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	G	G	G	
Increase our focus on complex-acute and specialty care	Regional Protocols for targeted patient populations are in place and reflect KGH's role	Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile - (QIP)	G	G	R	R	Y	↑
		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
Q3 F2013-14

			13-Q3	13-Q4	14-Q1	14-Q2	14-Q3
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	Y	R	R	Y
		OHS - Management Inspection Program	R	G	G	R	Y
		OHS - Respirator Fit Testing & Training Compliance	Y	Y	R	R	R
		OHS - WSIB NEER Performance Index - 2009	Y	Y	Y	G	G
		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	G	G	G	G	G
		OHS - Incident Investigations Complete	R	R	Y	R	R
		OHS - Lost Time Severity Rate (Days Lost/100 Workers)	N/A	N/A	Y	R	R
		OHS - Needlestick Injuries (NSI's) Only	R	R	G	R	R
		OHS - Total MSI Incidents	R	Y	Y	Y	Y
		OHS - MSI Lost Time Injury Claims (LTIs)	G	G	G	G	Y
		OHS - MOL Reported Critical Injury Incident	G	G	G	Y	G
		OHS - WSIB Lost Time Claims	G	G	G	G	Y

117	13-Q3	13-Q4	14-Q1	14-Q2	14-Q3
OHS - WSIB Health Care Claims	R	R	Y	Y	R
OHS - Occupational Illness Reported to MOL	G	Y	G	G	G
OHS - MOL Orders Issued During Site Visit	R	G	G	G	G
OHS - Mandatory Safety Training (Overall Compliance)	Y	Y	Y	R	R
OHS - Pre-Placement Health Screening Completed	G	G	G	Y	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

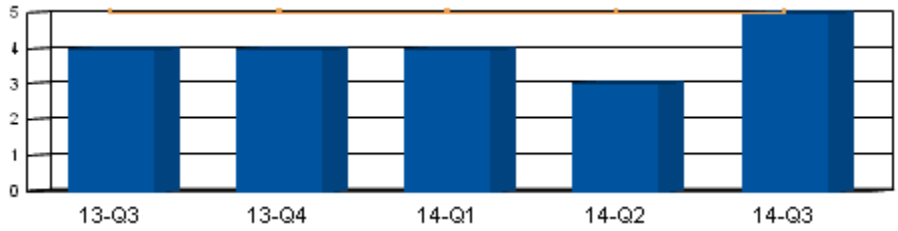
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB Lost Time Claims



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

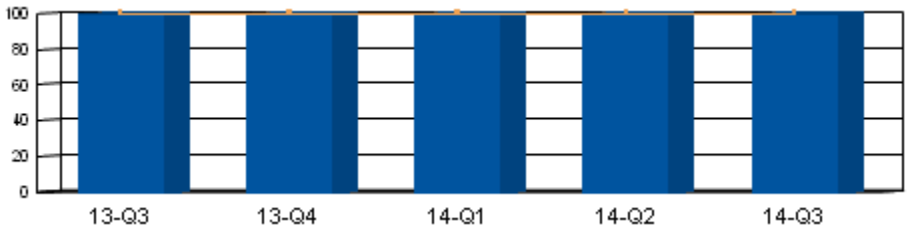
Interpretation - Patient And Business:

The location of the 5 LTIs were as follows: Medicine (2), Environmental Services (1), SPA (1), and Facilities (Stairwell-1). 3 LTI's were caused by Musculoskeletal Injury (MSI), 1 by a fall and 1 was 'struck/caught by' type of injury to the head.

Definition:

Target: Target 2013/14:

Indicator: OHS - JHSC Health & Safety Inspections Completed

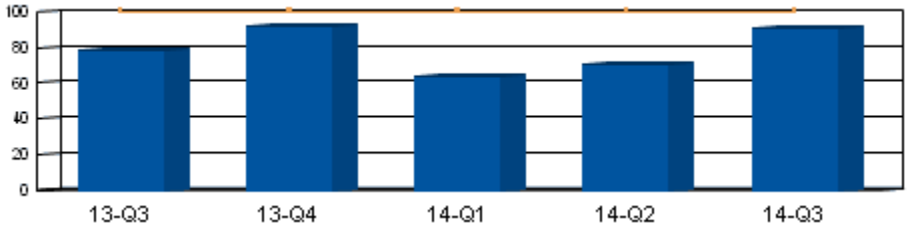


	Actual	Target
13-Q3	100	**100**
13-Q4	100	**100**
14-Q1	100	**100**
14-Q2	100	**100**
14-Q3	100	**100**

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

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

Indicator: OHS - 21 Day Response to JHSC Identified Hazards



	Actual	Target
13-Q3	78	**100**
13-Q4	92	**100**
14-Q1	64	**100**
14-Q2	71	**100**
14-Q3	91	**100**

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

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

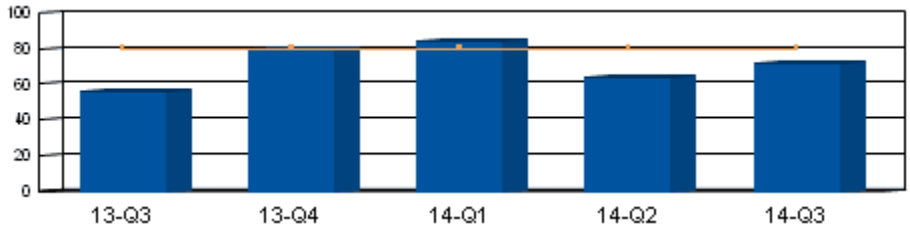
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Management Inspection Program

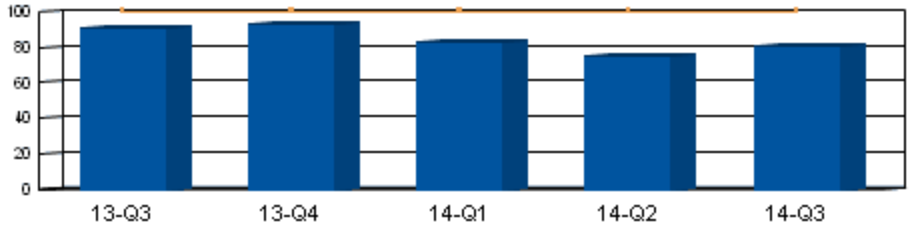


	Actual	Target
13-Q3	56	≥80
13-Q4	80	≥80
14-Q1	84	≥80
14-Q2	64	≥80
14-Q3	72	≥80

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-Q3	91	100
13-Q4	93	100
14-Q1	83	100
14-Q2	75	100
14-Q3	81	100

Interpretation - Patient And Business:

Q3 completion rate is 81% up from 75% in Q2. In an effort to reassess respirator fit testing needs and determine opportunities for improvement, a focus group met in Q3. OHSW has also been networking with other teaching hospitals to determine what practices they have in place to achieve compliance.

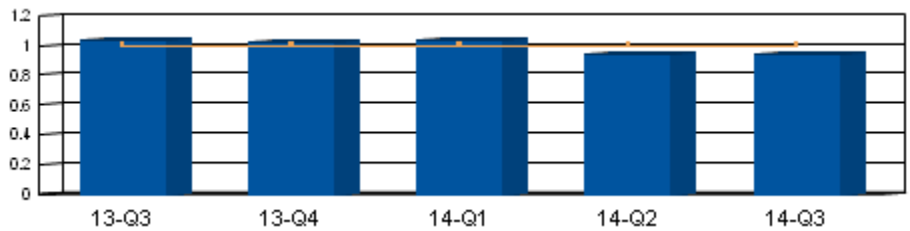
Actions & Monitoring Underway to Improve Performance:

A number of improvements are being examined including use of a scheduling system by staff to self schedule, reduction in the number of staff requiring testing based on likelihood of donning a respirator in their daily work, development of a management template to be used to communicate fit testing expectations to staff who are overdue, etc.

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-Q3	1.04	≤1
13-Q4	1.02	≤1
14-Q1	1.03	≤1
14-Q2	0.94	≤1
14-Q3	0.94	≤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

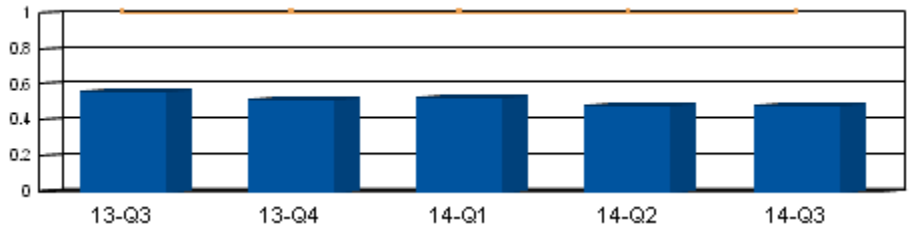
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2010

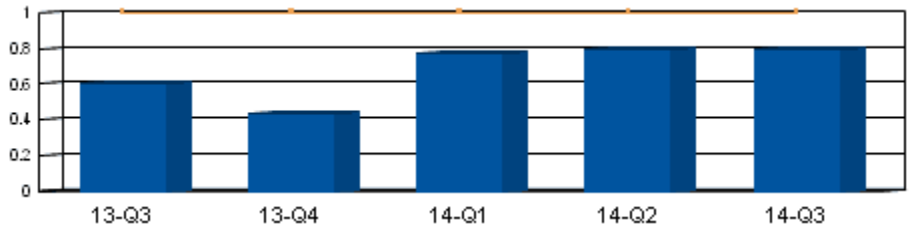


	Actual	Target
13-Q3	0.56	≤1
13-Q4	0.51	≤1
14-Q1	0.52	≤1
14-Q2	0.48	≤1
14-Q3	0.48	≤1

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

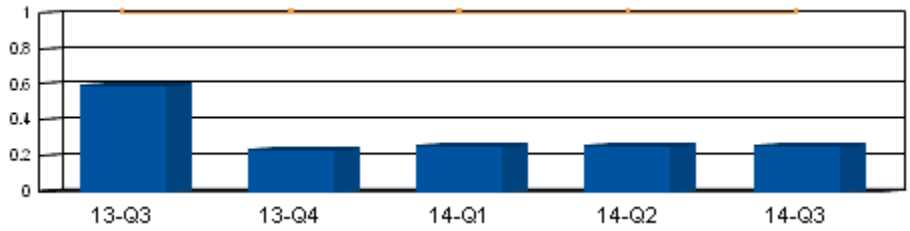


	Actual	Target
13-Q3	0.60	≤1
13-Q4	0.44	≤1
14-Q1	0.77	≤1
14-Q2	0.80	≤1
14-Q3	0.80	≤1

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	0.25	≤1
14-Q3	0.25	≤1

Interpretation - Patient And Business:

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

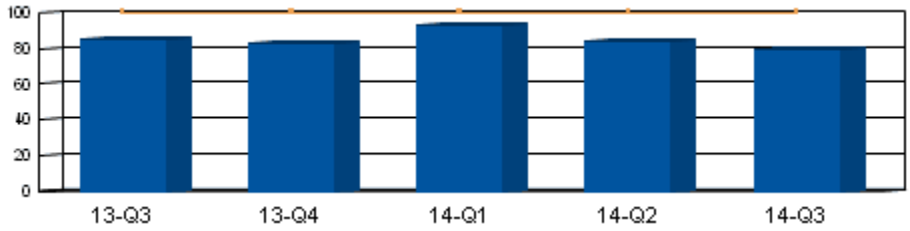
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Incident Investigations Complete



	Actual	Target
13-Q3	85	**100**
13-Q4	83	**100**
14-Q1	93	**100**
14-Q2	84	**100**
14-Q3	80	**100**

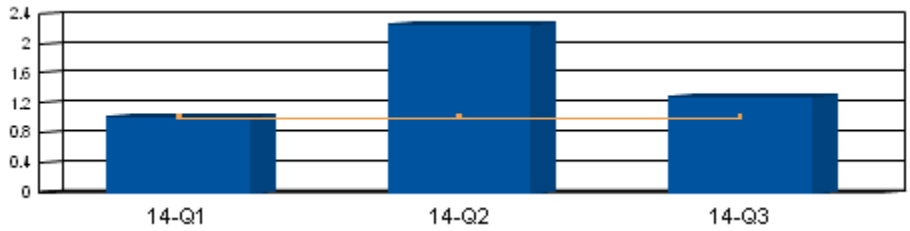
Actions & Monitoring Underway to Improve Performance:

Supervisory Training that addresses incident investigation in being rolled out to all leaders in Q4. The new version of Safe Reporting has been configured to better capture the status of the manager's investigation.

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
14-Q1	1.0	**<1**
14-Q2	2.3	**<1**
14-Q3	1.3	**<1**

Interpretation - Patient And Business:

Although only 9 days were lost this quarter related to injuries occurring in Q3, there were another 29 days lost related to 2 earlier injuries, one being a 2011 injury that resulted in time off in Q3 of this year.

Actions & Monitoring Underway to Improve Performance:

Although we are avoiding considerable lost time through case management and the provision of modified duties (Q3 had a total of 341 modified work days due to workplace injury), the more effective strategy is an organizational focus on injury prevention.

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

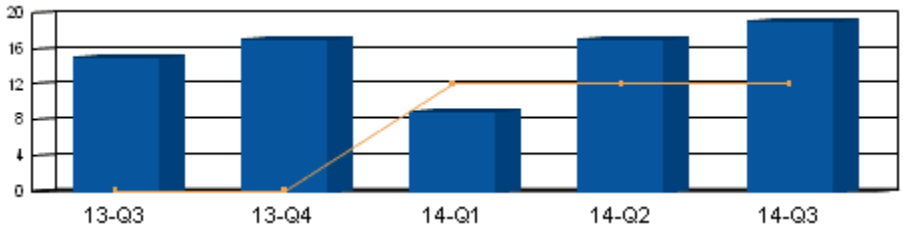
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

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



	Actual	Target
13-Q3	15	**0**
13-Q4	17	**0**
14-Q1	9	**≤12**
14-Q2	17	**≤ 12**
14-Q3	19	**≤ 12**

Interpretation - Patient And Business:

Top 3 programs for NSIs- Obs/Gyn (5), SPA (5), and Medicine (3). 30% of NSIs occurred during suturing with a suture needle; another 30% involved a safety engineered needle.

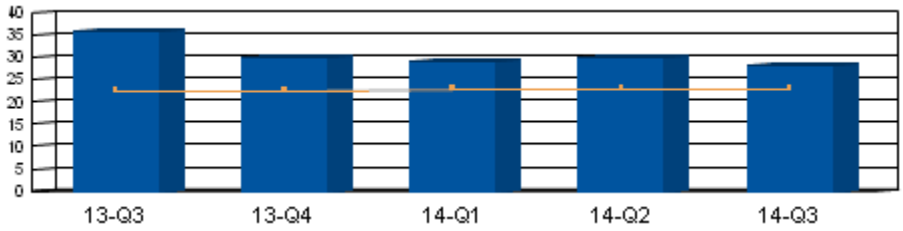
Actions & Monitoring Underway to Improve Performance:

Needle Safety awareness training to be rolled out to all clinical staff by end of Q4; converting to safety engineered ABG syringe in Q4, currently assessing opportunity to convert from syringes to pens for administration of insulin for improved safety. New version of Safe Reporting has been configured to improve data collected on needlestick injuries and has resulted in modification to the Management form to facilitate improved investigation and management of NSIs.

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-Q3	36	**≤ 23**
13-Q4	30	**≤ 23**
14-Q1	29	**≤ 23**
14-Q2	30	**≤ 23**
14-Q3	28	**≤ 23**

Interpretation - Patient And Business:

Incidence of reported MSIs in Q3 was consistent with previous quarters this year. As noted above, 3 MSIs resulted in lost time injury (LTI) claims. Of the 28 MSIs, 43% were due specifically to patient handling activities and 57% to all other causes. Program with highest incidence of patient handling-related MSIs was Medicine (58%).

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

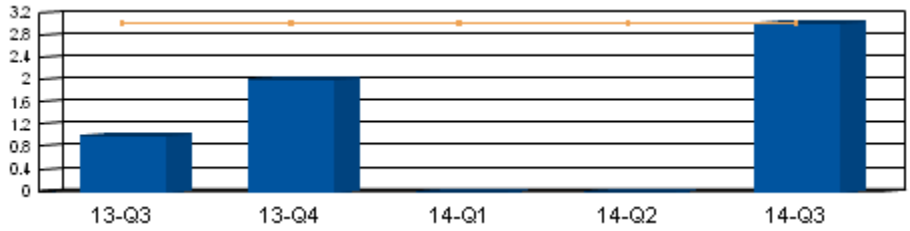
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

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



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

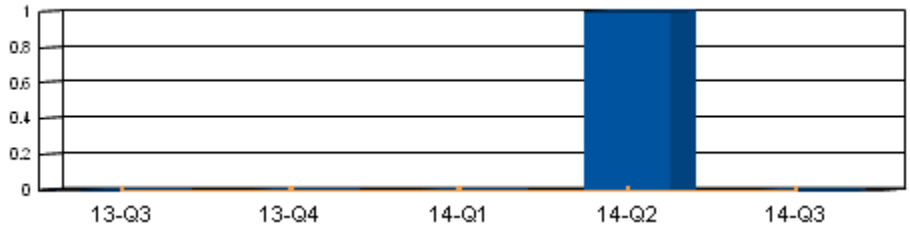
Interpretation - Patient And Business:

The 3 MSIs that resulted in lost time from work occurred in Medicine (2) and Kidd 3 (1). One was related to patient handling, 1 occurred during patient care and the other related to an administrative task. In all, these 3 claims resulted in 5 lost days from work.

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

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

Indicator: OHS - MOL Reported Critical Injury Incident

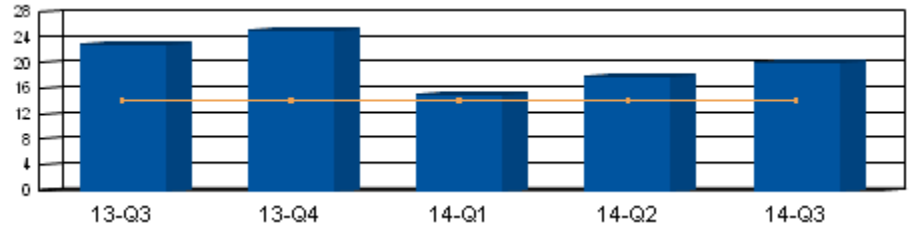


	Actual	Target
13-Q3	0	0
13-Q4	0	0
14-Q1	0	0
14-Q2	1	0
14-Q3	0	0

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

Target: Target 2012/13: 0, Target 2013/14: 0

Indicator: OHS - WSIB Health Care Claims



	Actual	Target
13-Q3	23	<14
13-Q4	25	<14
14-Q1	15	<14
14-Q2	18	<14
14-Q3	20	<14

Interpretation - Patient And Business:

The 2 programs with highest incidence of health care claims were: SPA (5) and Environmental Services (3).
The 2 most common types of incidents that resulted in the health care claims were musculoskeletal (n=8) and exposure to hazardous/harmful environment -allergic reaction to new gloves (2), scent exposure (1), chemical splash (1).

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

Target: Target 2012/13: <= 54, Target 2013/14: <= 54

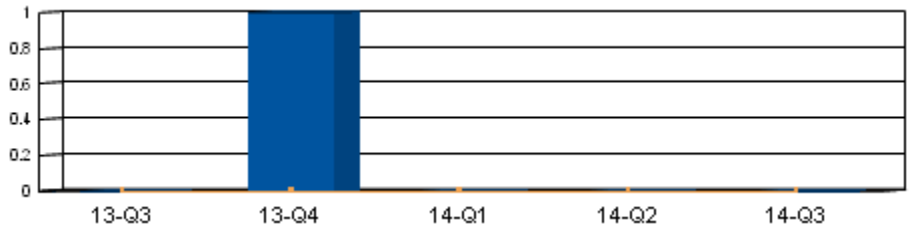
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Occupational Illness Reported to MOL

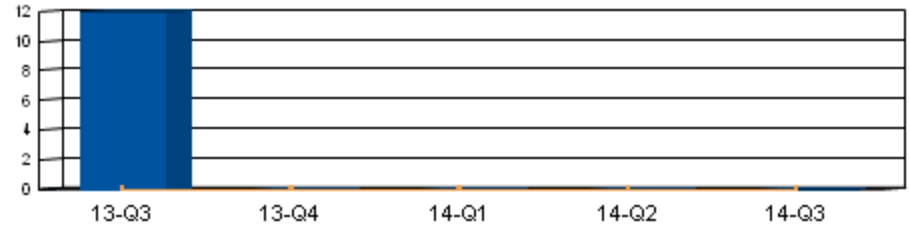


	Actual	Target
13-Q3	0	**0**
13-Q4	1	**0**
14-Q1	0	**0**
14-Q2	0	**0**
14-Q3	0	**0**

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

Target:

Indicator: OHS - MOL Orders Issued During Site Visit



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

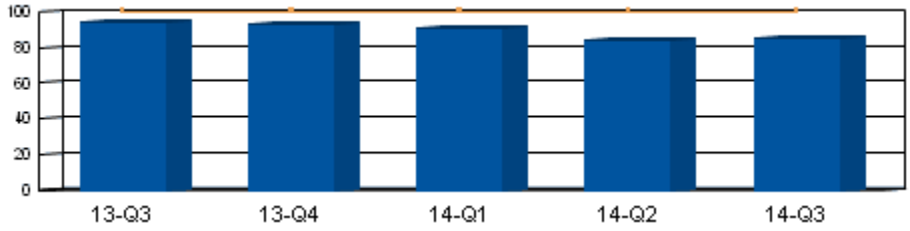
Interpretation - Patient And Business:

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-Q3	94	**100**
13-Q4	93	**100**
14-Q1	91	**100**
14-Q2	84	**100**
14-Q3	85	**100**

Interpretation - Patient And Business:

Workplace Violence & Harassment 97%, WHMIS 91%, MSI Prevention 93%, Safety Talks 58% (a new Safety Talks trainign bulletin was rolled out end of Nov 2013).

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%

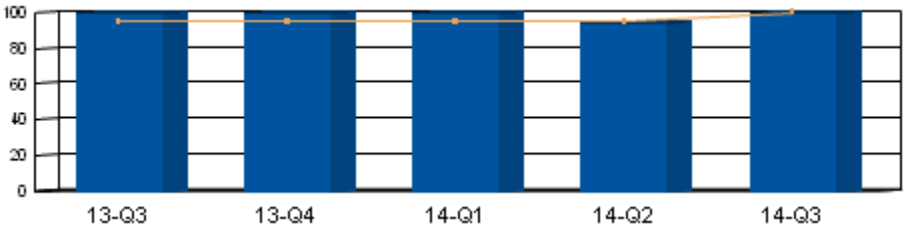
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Pre-Placement Health Screening Completed



	Actual	Target
13-Q3	100	**>95**
13-Q4	100	**>95**
14-Q1	100	**>95**
14-Q2	94	**≥95**
14-Q3	100	**>95**

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

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

Kingston General Hospital

Occupational Health and Safety Scorecard

Status:

	Currently Not Available
	Green-Meet Acceptable Performance Target
	Red-Performance is outside acceptable target range and require
	Yellow-Monitoring Required, performance approaching