fiscal 2013-2014 **Q4**

4th quarter ended March 31, 2013

KGH this quarter

Master Performance Report

Kingston General Hospital

Outstanding care, always

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Master Performance Report
Q4 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?** Patient Experience Advisors have been recruited to participate on priority improvement teams, with each receiving the same education program as provided to all leaders and participants. The advisors have been preferentially included in initiatives aligned to the Gridlock and the patient safety initiatives reporting to the QPCC. With the knowledge and support of the Patient and Family Advisory Council, advisors have not been 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). To date, 12 advisors have completed the education and each of the 20 improvement teams now include advisors, In addition, one advisor was part of the overall Gridlock VSM process prior to the education programming being made available. Further note that advisors are part of many improvement initiatives beyond the corporate priorities reporting to QPCC.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Continued support for recruitment, education and integration of advisors on improvement teams. Engagement is proceeding for teams being configured to support new 2015 initiatives (i.e. avoidable admission/readmission team).

3. **Are we on track to meet the milestone by year end?** The intent and target for this milestone were met by year end.

4. **What new tactics are planned to ensure this milestone is met?** Continue to support education of advisors to be equal partners in the CI/VSM processes; recruit advisors to be available to become engaged in project work; 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.

   As a means of sustaining and improving advisor engagement, in F2015, we are planning to have an advisor satisfaction survey, including questions pertaining to satisfaction with committee/work team involvement and ways to make improvements. As well patient centred leadership tools, such as a guide for Chairing meetings with advisors are in development.

Kingston General Hospital

MS #01

			13-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	G	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	Y	Y	Y	N/A	↓
		Percent of Patients Who Respond "Satisfied" to the Food Patient Discharge Survey	R	R	R	R	R	↑
		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 ↓

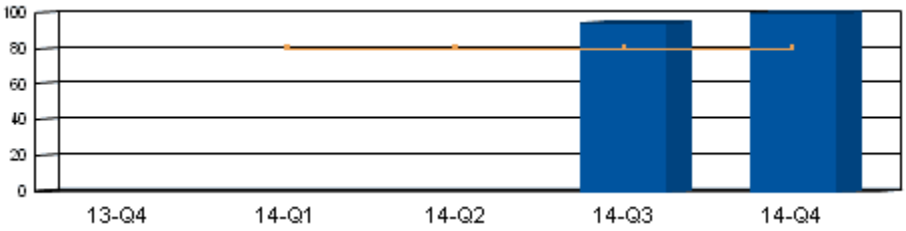
Kingston General Hospital

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-Q4		
14-Q1		**80**
14-Q2		**80**
14-Q3	94	**80**
14-Q4	100	**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, 20 of 20 improvement teams now include advisors, 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:

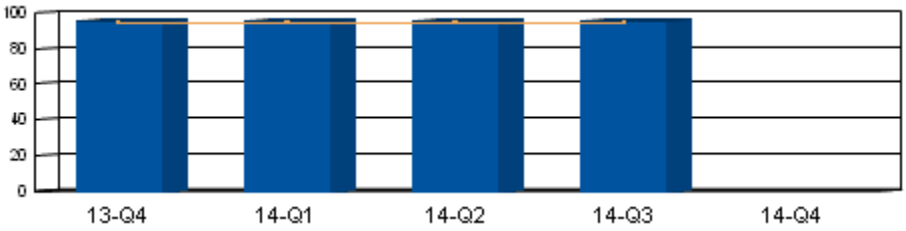
Continue to support education of advisors as it enables them to be equal partners in the CI/VSM processes; recruit advisors to be available to consider and become engaged in project work; support the process to catalogue their work and involvement; celebrate the involvement in the accomplishments of 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-Q4	95	**94**
14-Q1	95	**94**
14-Q2	95	**94**
14-Q3	95	**94**
14-Q4		

Interpretation - Patient And Business:

We continue to monitor and use as a guide the various mechanisms for patient feedback. Currently have both corporate and program specific initiatives underway aligned to the NRCC eight dimensions of care and patient flow.

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%

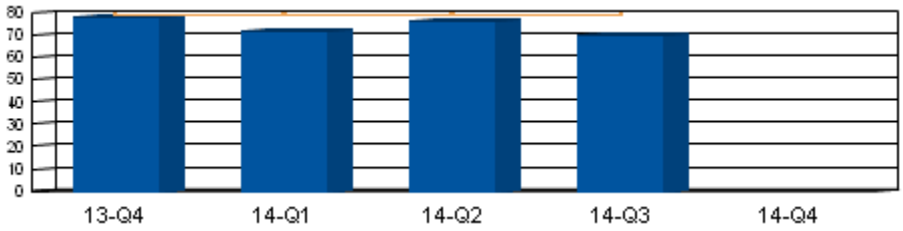
Kingston General Hospital

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-Q4	78	**79**
14-Q1	72	**79**
14-Q2	76	**79**
14-Q3	70	**79**
14-Q4		

Interpretation - Patient And Business:

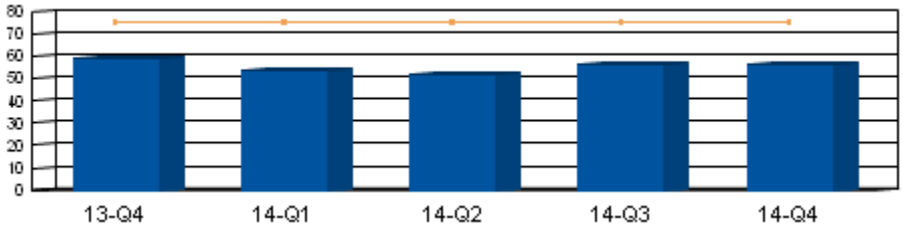
We continue to monitor and use as a guide the various mechanisms for patient feedback. Currently have both corporate and program specific initiatives underway aligned to the NRCC eight dimensions of care and patient flow.

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-Q4	59	**75**
14-Q1	54	**75**
14-Q2	52	**75**
14-Q3	57	**75**
14-Q4	57	**75**

Interpretation - Patient And Business:

The overall patient satisfaction score from the Compass survey for Q4 reporting was 94%. The target for fiscal 2014 is 78% at the enthusiastic level (i.e. excellent/very good). The corresponding "enthusiastic "score for Q4 was 56%. No survey was undertaken in Q3.
The information provided by the NRCC survey for Q3 (indicated as the result above) indicates an increase over Q2 results (Q3 56.5%, Q2 51.7%).
The academic teaching hospital average score for Q3 was 59.6%.

Actions & Monitoring Underway to Improve Performance:

The decline in the Compass overall patient satisfaction score mirrors the results from NRCC. The reduction in the "enthusiastic" rating is concerning. A detailed review of the score results with particular emphasis on comments provided by patients will be undertaken with Compass management to determine action items necessary to generate improvement. A new survey will be undertaken in Q1 fiscal 2015.

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%

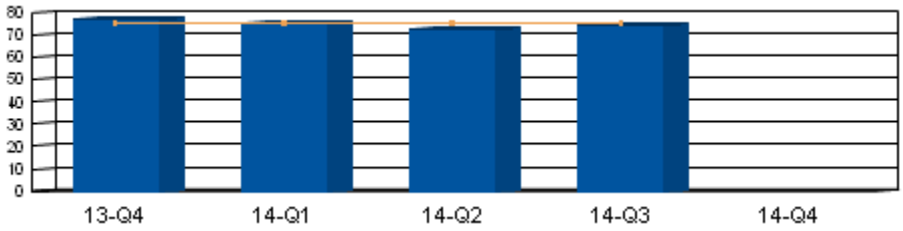
Kingston General Hospital

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-Q4	77	**75**
14-Q1	75	**75**
14-Q2	73	**75**
14-Q3	74	**75**
14-Q4		

Interpretation - Patient And Business:

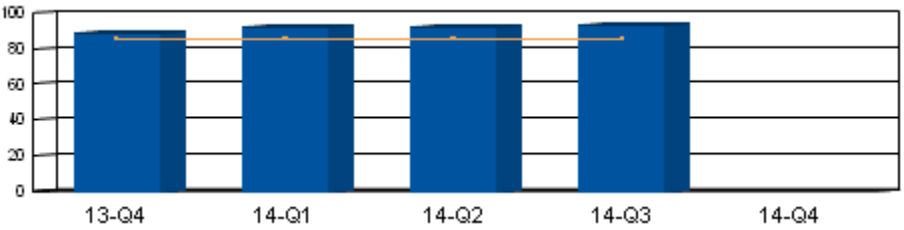
Q4 data not yet available. This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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-Q4	88	**85**
14-Q1	92	**85**
14-Q2	92	**85**
14-Q3	93	**85**
14-Q4		

Interpretation - Patient And Business:

Q4 data 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?

The 4 primary improvement priorities have shown a good improvement since Q3 with 1 green, 2 yellow and one red (previously 1 green and 3 red). The 'number of new acquired infections' remained green and only the 'Achieve zero patient falls in L3 and L4 categories' remains red.

In Q4 there were 5494 admissions with only 22 acquired nosocomial infections (0.4% of admissions) against a target of 31. Specimen collection errors also showed a very significant decrease compared to F13 Q4: Glucose meter incidents down 49% (659 to 338); Blood collection errors down 70% (261 to 81); Urine collection vial leakage down 62% (255 to 96). Level 3 and 4 fall incidence remained at 3 during Q4. Each underwent a Quality of Care Review. Three medication (fluid) error projects were implemented during fiscal 14 with completion of only one (electronic inpatient chemotherapy order entry). Implementation of a comprehensive strategy for safe management of insulin is just being initiated. Reduction of the incidence of morphine and hydromorphone administration incidents through implementation of automated dispensing cabinets is approximately 50% completed. The first 6 months of the project on 50% of the wards has seen a decrease of 24 to 13 incidents (46% reduction).

The 21/23 reporting indicators in the milestone are 76% favourable (16 G,Y) with 5 red. This is improved 5% from Q3 with 'Specimen errors' and "Medical fluid events' both converting red to yellow.

RE: Hand Hygiene: In Q3 the Infection Prevention and Control (IFC) service initiated a blitz on signage and education in light of the decreasing rates Q1 – Q3. This did result in an increase in Q4 to 88.22%.

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)

- Aggressive campaign by the IPC team to target increased HH auditing
- Implementation of the phlebotomy team in ED, clinics, and cancer center
- Education and working with programs to improve glucose meter and urine collection protocols

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

The milestone did not reach target this fiscal year but did see improvement and positive trending. HSMR continues to trend downwards to less than 100% i(Q3 data). Reviews of mortality within 5 days of major surgery began in Q4.

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

Tactics will be aligned to the F15 Integrated Annual Corporate Plan and QIP 2015. Large education/engagement underway on fall prevention through the Falls Committee.

Kingston General Hospital

MS #02

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

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

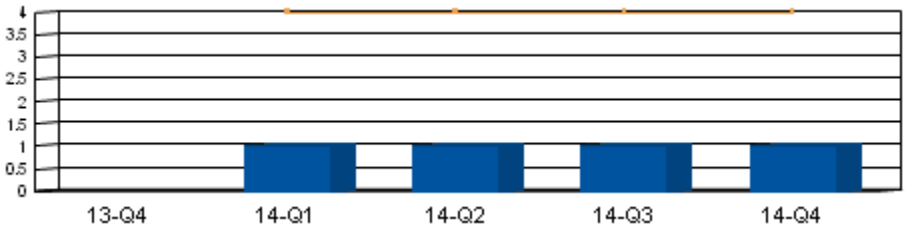
Kingston General Hospital

MS #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-Q4		
14-Q1	1	**4**
14-Q2	1	**4**
14-Q3	1	**4**
14-Q4	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 will be a focus for the next fiscal year.

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

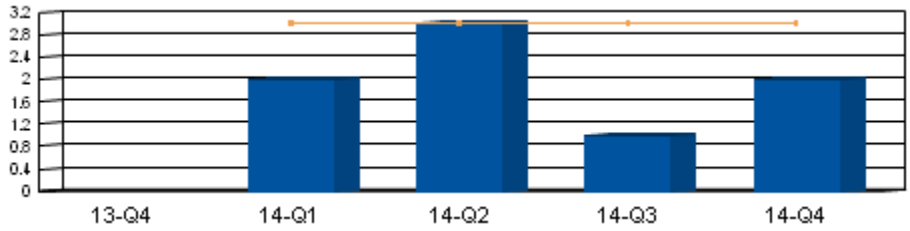
Kingston General Hospital

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: Reduce the top 3 errors associated with specimen collection



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

Interpretation - Patient And Business:

Deviation from standard operating procedure (Glucose connectivity). Q4 update: Meetings involving Nursing Practice Council and with Clinical Educators now complete. Changes recommended are ready for implementation. New policies and procedures are in the final stages of endorsement and then will be implemented. Areas with high incidence of non-compliance have been identified and the POCT MLT/manager and Program managers are working together to address non-compliance. POCT department will continue to provide data. Inconsistencies in data reporting have resulted in not reliable data in the SAFE reporting tool. POCT department has the ability to pull data and has seen a decrease in the number of failed transmissions, this is seen as a good indication that education and working with stakeholders is resulting in a decrease overall in the number of incidents of deviations from the standard operating procedures.

ID specimen mismatch/unlabeled; Q4 update: standard work now in place in ED, FAPC and Cancer centre with the phlebotomy team, final team complement hired but then staff sickness has resulted in additional staff required. The phlebotomy team has started on 2 inpatient units (surgical floors which will support GRIDLOCK initiatives) completing morning draws, feedback to date very positive. Meeting will be setup to include all stakeholders (patient, phlebotomist, physician, nursing and lab) to make sure all stakeholders' needs have been met. Work continues in this area but at a very slow pace in the absence of a project manager.

Leaky urine update: Q4 report: positive trending seen in Q3 continues in Q4. Will continue to monitor over the next several quarters in F'15 to ensure issue has been addressed.

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

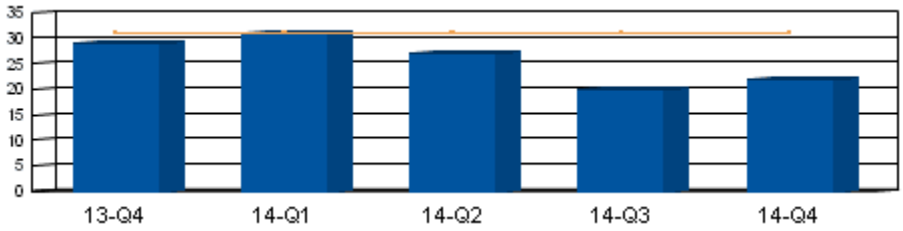
Kingston General Hospital

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-Q4	29	**31**
14-Q1	31	**31**
14-Q2	27	**31**
14-Q3	20	**31**
14-Q4	22	**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 4, we had 3 MRSA bacteremias, 3 VRE bacteremias and 16 cases of CDI for a total of 22 infections which is two more infections than Quarter 3.

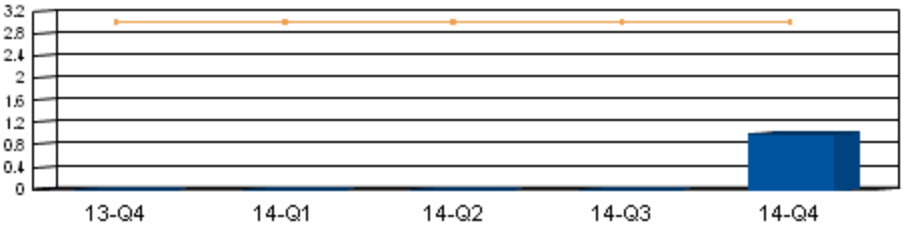
Business Perspective: The target reduction has been achieved principally due to a decrease in CDI infections over the last 19 months.

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

Interpretation - Patient And Business:

The electronic inpatient chemotherapy order entry project was successfully implemented in February 2014.
The other two projects selected in F14 (1. Reduce the incidence of morphine and hydromorphone administration incidents through the implementation of automated dispensing cabinets and 2. Implement a comprehensive strategy for the safe management of insulin, including standardization of prescribing, storage , dispensing and administration processes are ongoing)

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

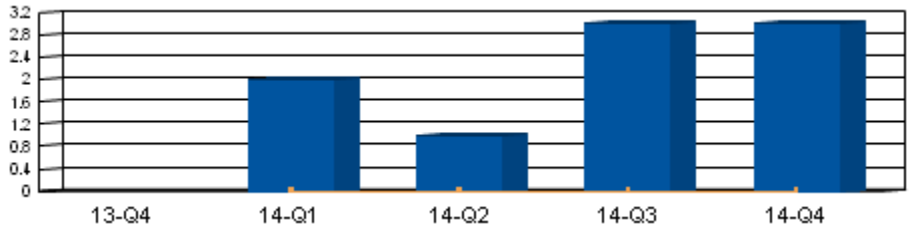
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

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



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

Interpretation - Patient And Business:

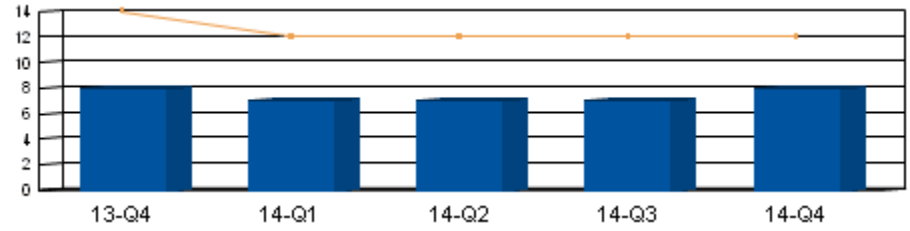
In Q4 there were two severe/critical (level 4) falls and one moderate (level 3) fall.
The Falls tactic team F2015 workplan includes a 3 hr education (MOVE ON and Falling Star refresher) for all unit teams in Q1. Q2 will see all unit areas implementing the education with their staff using a peer champion model. The Q3/Q4 focus will be on auditing and sustainability of falls and mobility patient assessment & documentation & intervention strategies.

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

Interpretation - Patient And Business:

Performance has improved slightly from the last quarter with 8/12 indicators green or yellow. The mortality review indicator remains NA as this process has been replaced with 2 more specific mortality review indicators for fiscal 14/15.

Actions & Monitoring Underway to Improve Performance:

Hand hygiene, falls and e-discharges remain a focus for improvement for fiscal 14/15

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

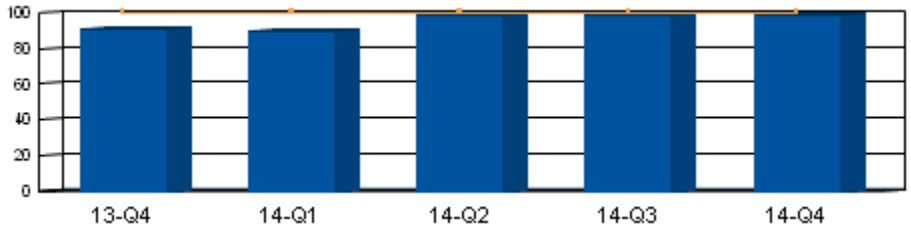
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

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



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

Interpretation - Patient And Business:

For Q4 this indicator continues to meet the green target corridor. There were 2,294 surgical cases completed in this quarter. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.1%, Timeout-99%, and Debrief- 98%. The unscheduled/emergent cases and consistent compliance to the Surgical safety checklist completion is an area of focus for the next quarter.

Actions & Monitoring Underway to Improve Performance:

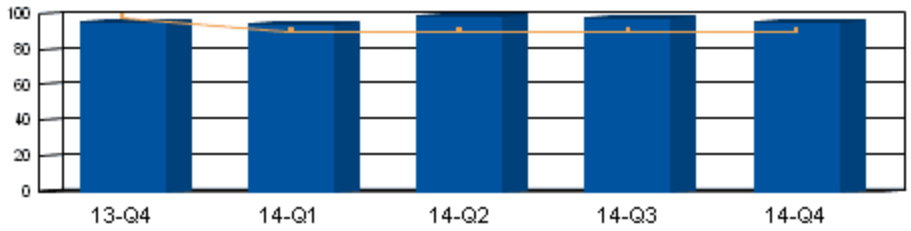
Working group has been created to review opportunities for improvement to achieve total compliance. SPA program council continues to manage and monitor this indicator.

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-Q4	95.0	**98**
14-Q1	94.0	**90**
14-Q2	99.0	**90**
14-Q3	97.0	**90**
14-Q4	95.3	**90**

Interpretation - Patient And Business:

Patient Perspective: The appropriate timing of prophylactic antibiotic administration for primary hip and knee replacements reduces the risk of patients developing postoperative surgical site infections. In January our compliance was 96.7%, February's compliance was 97% and for March our compliance was 92.9%.

Business Perspective: We have met the target for 2013-2014 in all 4 quarters. 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 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

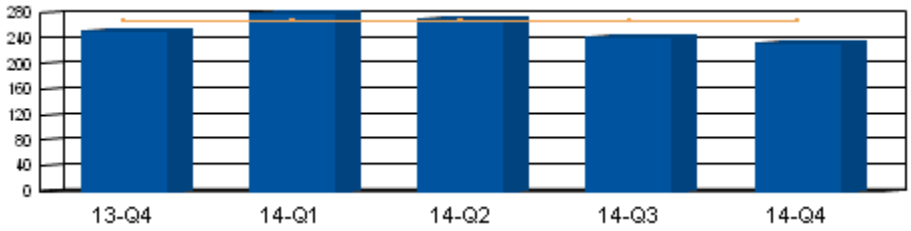
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

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



	Actual	Target
13-Q4	252	**267**
14-Q1	278	**267**
14-Q2	271	**267**
14-Q3	243	**267**
14-Q4	232	**267**

Interpretation - Patient And Business:

The designated target level for this QIP (<267 DDD/1000 patient-days) has been surpassed and sustained for two consecutive quarters. However, utilization numbers are likely to be revised as inventory correction reconciles utilization data slightly upward. During this last quarter, there were no logged interventions by KGH ASP in the Critical Care Program. Re-institution of the KGH ASP into the ICUs would allow for maintenance of ideal levels of antibiotic utilization across the institution and even a further modest reduction.

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%

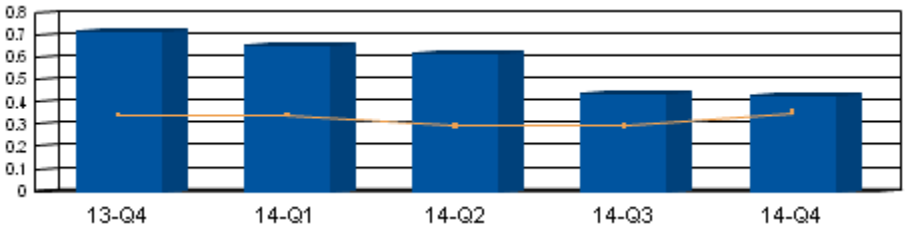
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: C-Difficile (Reported Monthly)



	Actual	Target
13-Q4	0.72	**0.34**
14-Q1	0.65	**0.34**
14-Q2	0.62	**0.29**
14-Q3	0.44	**0.29**
14-Q4	0.43	**0.35**

Interpretation - Patient And Business:

Patient Perspective: The last 5 quarters monthly values were: November - 4 cases; December - 1case; January - 9 cases; February 2 cases and March 5 cases.

Business Perspective: We currently have been 22 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

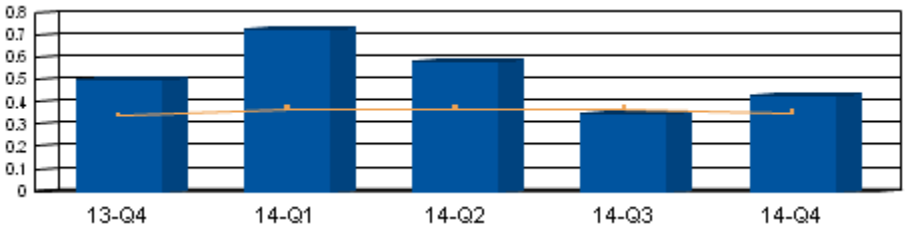
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: C-Difficile (Reported Quarterly)



	Actual	Target
13-Q4	0.50	**0.34**
14-Q1	0.73	**0.37**
14-Q2	0.58	**0.37**
14-Q3	0.35	**0.37**
14-Q4	0.43	**0.35**

Interpretation - Patient And Business:

Patient Perspective: The KGH rate for this quarter was 0.43 cases per 1000 patient days; a modest increase from the third quarter. In January we had 9 cases of CDI. In February we had 2 cases and in March there were 5 cases giving us a total of 16 cases for this quarter; in comparison to Quarter 1, where we had 27 cases, Quarter 2 where we had 21 cases and Quarter 3 where we had only 13 cases.
Institution perspective: We continue a steady downward trend in CDI cases, which has been sustained for > 2 years. Multiple inputs into this sustained improvement include: diversion of IPAC resource time to CDI from VRE, ASP, better laboratory testing, a new CDI order set with SOPs, environmental cleaning and high hand hygiene rates.
Business Perspective: For 2013 - 2014 we had 77 cases of CDI. This is a decrease from 2012 - 2013 when we had a total of 88 cases. IPAC continues to work with all Programs to improve the identification of cases from the community and other facilities 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

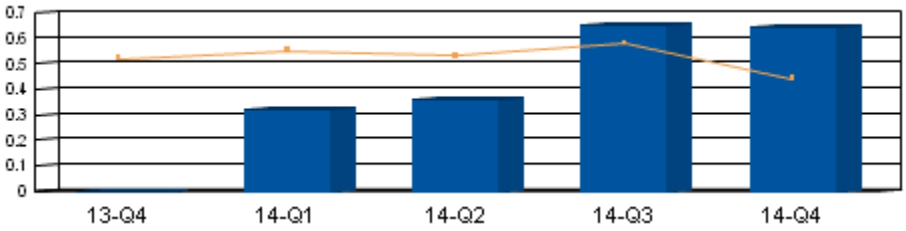
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Central Line Bloodstream Infections



	Actual	Target
13-Q4	0.00	**0.52**
14-Q1	0.32	**0.55**
14-Q2	0.36	**0.53**
14-Q3	0.65	**0.58**
14-Q4	0.64	**0.44**

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

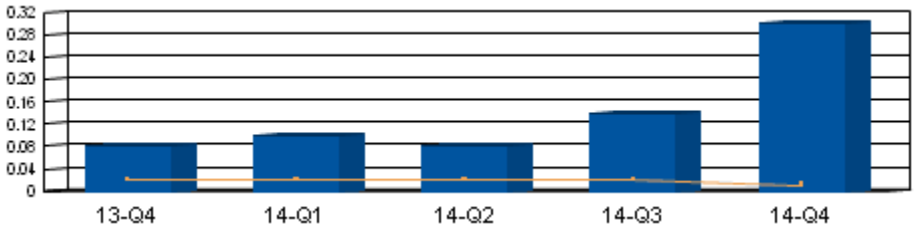
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: MRSA (Methicillin-resistant Staphylococcus Aureus)



	Actual	Target
13-Q4	0.1	**0.02**
14-Q1	0.1	**0.02**
14-Q2	0.1	**0.02**
14-Q3	0.1	**0.02**
14-Q4	0.3	**0.01**

Interpretation - Patient And Business:

Patient Perspective: The rate of MRSA bacteremias for this quarter was 0.3 per 1000 patient days which represents only 3 cases. This is a decrease from Quarter 3 when we had 5 cases and a rate of 0.14. We had a single case in January, 0 cases in February and 2 cases in March. Based on our current patient days, the target as indicated represents less than 1 case per quarter.

Business Perspective: IPAC Service continues to support each Program and identify opportunities to improve their compliance with the MRSA Admission Screening Medical Directive. Our recent monthly compliance rates averages are still below 50% therefore we miss identifying patients when they are admitted as colonized/infected and as a result must call them nosocomial to KGH when they are later identified as positive, as the rate of MRSA in the community is increasing. We are also missing opportunities to screen patients on admission from other facilities. A concern attributed to these misses is that KGH's nosocomial rate for MRSA may be lower than what we are reporting. Finally, there is a causal link between hand hygiene rates and the rate of MRSA colonization and infection. The modest increase in MRSA infections overall suggest its link to recent downward trends in HH rates.

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

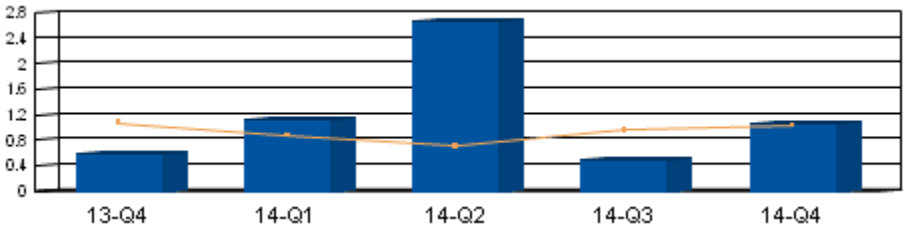
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: Ventilator Associated Pneumonia



	Actual	Target
13-Q4	0.60	**1.07**
14-Q1	1.13	**0.87**
14-Q2	2.66	**0.70**
14-Q3	0.48	**0.95**
14-Q4	1.07	**1.03**

Interpretation - Patient And Business:

Rate is lightly above target but related to a decrease in percent of ventilator days reducing the denominator and increasing the impact of the 3 cases that were documented to have VAP this quarter.

Actions & Monitoring Underway to Improve Performance:

If the percentage of ventilator days was greater than 61%, the rate likely would have been within current expected norm. Continue to monitor closely to ensure a trend has not developed.

Definition: DATA: CCIS COMMENTS: 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

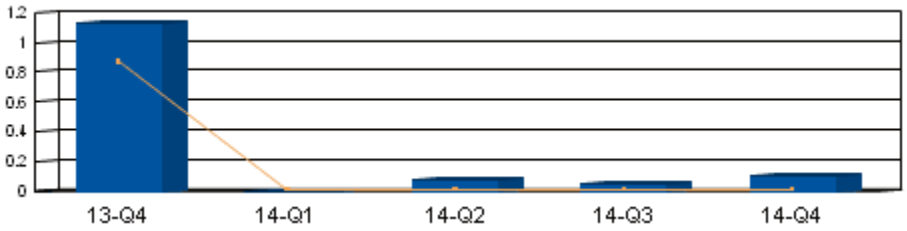
Kingston General Hospital

MS #02

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

The top sources of preventable harm to patients are addressed

Indicator: VRE (Vancomycin-resistant Enterococcus)



	Actual	Target
13-Q4	1.13	**0.87**
14-Q1	0.00	**0.01**
14-Q2	0.08	**0.01**
14-Q3	0.05	**0.01**
14-Q4	0.10	**0.01**

Interpretation - Patient And Business:

Patient Perspective: The rate of VRE bacteremias for this quarter was 0.1 per 1000 patient days which represents 3 cases. We experienced 2 cases in January, 1 case in February and 0 cases in March. This is a clinically irrelevant increase from Quarter 3 when we had 2 cases and our rate was 0.05 per 1000 patient days. There was no attributable mortality for any of the 3 VRE bacteremias.

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

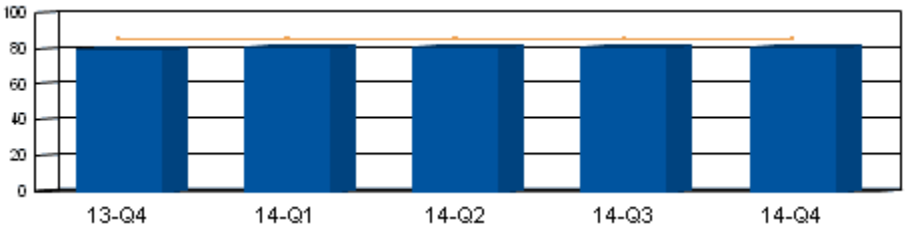
Kingston General Hospital

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: External Environmental Audits by Westech



	Actual	Target
13-Q4	79	**85**
14-Q1	81	**85**
14-Q2	81	**85**
14-Q3	81	**85**
14-Q4	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 March 2014 audit report with a score of 81%. This score has remained consistent however below our target of 85%.

Actions & Monitoring Underway to Improve Performance:

We have been involved with Westech since March 2011. The Westech cleaning standard is a very detailed cleaning audit that has required very extensive training of both staff and managers. Although improvement has been demonstrated work continues to achieve the 85% target. We review the audits results and look for opportunities to improve.
Recently implemented between case cleaning in the operating room as part of our quality improvement plan.

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%

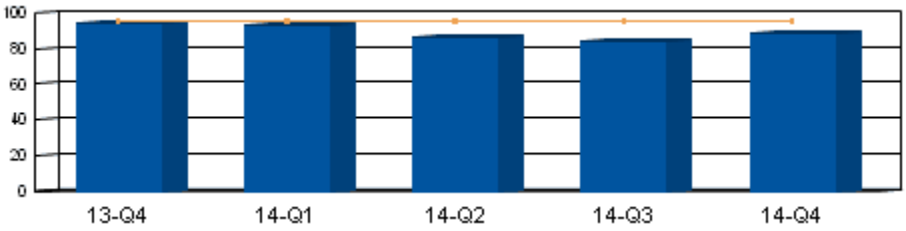
Kingston General Hospital

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-Q4	94.0	**95**
14-Q1	93.0	**95**
14-Q2	86.3	**95**
14-Q3	83.7	**95**
14-Q4	88.2	**95**

Interpretation - Patient And Business:

Patient Perspective: IPAC Service continues to train new hygiene auditors. In the last quarter we have added 7 new auditors. IPAC Service continues to work with and support the auditors recognizing the time it takes to become skilled with the device and how to identify and capture all hand hygiene opportunities. Auditors continue to be 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 circumstances where further clarification of interpreting activities during the auditing process was required.

Business Perspective: For this quarter we captured 1647 indications of Moment 1(before initial patient/patient environment contact). KGH's annual totals for Moment 1 were 5466 indications and 6632 indications for Moment 4 (after patient/patient environment contact). It is important to note that the annual numbers submitted to the MoHLTC include only the data for in-patient units and does not include the data from our numerous clinic areas. KGH's annual submission to the MoHLTC was submitted the end of March. Our HH compliance total for in-patient units was only 84.9%.

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%

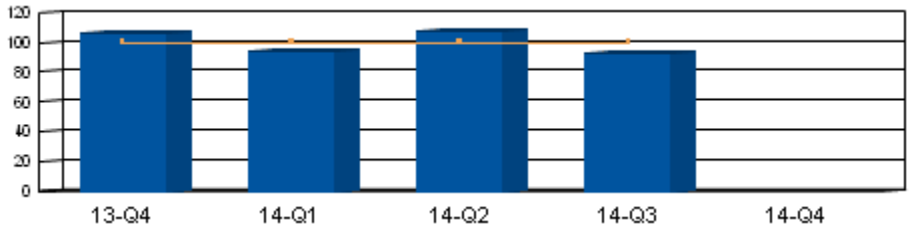
Kingston General Hospital

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-Q4	106	**100**
14-Q1	94	**100**
14-Q2	107	**100**
14-Q3	93	**100**
14-Q4		

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:

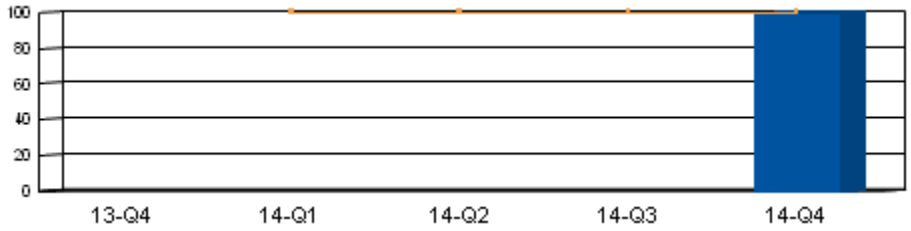
The most recent data available data from CIHI is Q3 of fiscal 13/14. The HSMR for Q3 was deemed not significant by the Canadian Institute for Health Information (CIHI) and the HSMR for Q4 is the lowest it has ever been. The Canadian Institute for Health Information (CIHI) provides the HSMR calculations 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-Q4		
14-Q1		**100**
14-Q2		**100**
14-Q3		**100**
14-Q4	100	**100**

Interpretation - Patient And Business:

This indicator has been in development and feasibility assessment. As planned the indicator was implemented in Q4 with excellent results. Of note, this indicator is 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%

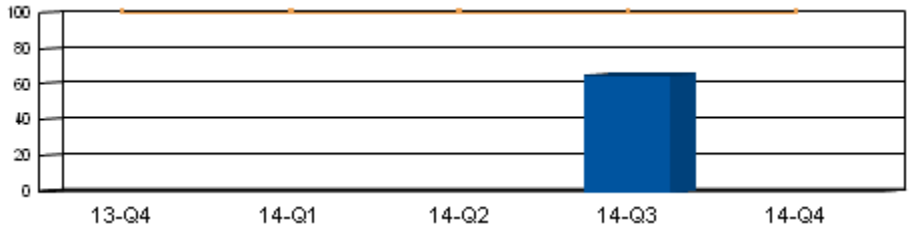
Kingston General Hospital

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-Q4		**100**
14-Q1		**100**
14-Q2		**100**
14-Q3	65	**100**
14-Q4		**100**

Interpretation - Patient And Business:

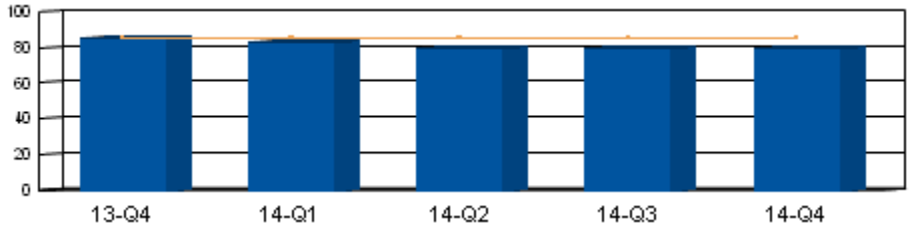
Mortality reviews, although completed, were not done in the time frame of a quarterly review period. Over 2 years of review, there have been no recommendations coming forward. As of Q4 last year, the process was redesigned to have the Departments to review mortality from the most recent quarter rather than historically identified through HSMR (up to 12-18 months later). A focus on mortality related to sepsis and 5 day post major surgery has been initiated to replace the current process.

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-Q4	85	**85**
14-Q1	83	**85**
14-Q2	80	**85**
14-Q3	80	**85**
14-Q4	80	**85**

Interpretation - Patient And Business:

The Q4 results are the results from the Oct 2013 -
Dec 2013 which are the most recent results from NRC + Picker Patient Satisfaction Survey which is conducted on discharge. Survey remains consistent with the last quarter.

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%

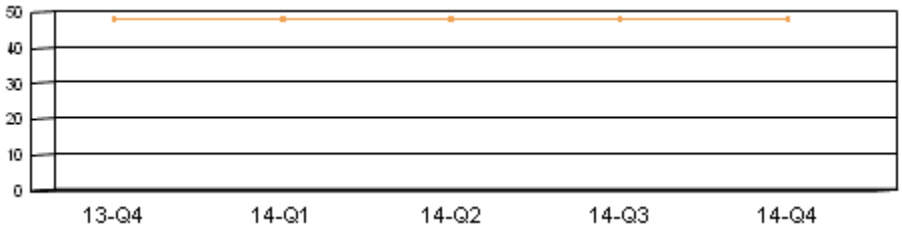
Kingston General Hospital

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-Q4		48
14-Q1		48
14-Q2		48
14-Q3		48
14-Q4		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: 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%

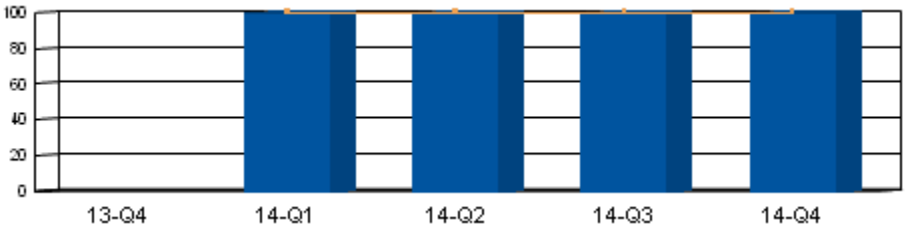
Kingston General Hospital

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

Interpretation - Patient And Business:

Five Quality of Care Reviews were held in Q4. Three of the QCRs are related to patient falls with 14 resulting recommendations; 8 are complete and 6 are currently in progress. Two of the QCRs are related to CareTreatment issues resulting in 11 recommendations; 7 are complete and 4 are currently in progress.

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 Q4, there were 9 Gridlocks totaling 536 hours. This compares to 7 Gridlocks and 435 hours in last year in the same quarter. For fiscal13/14 there were a total of 18 Gridlocks totaling 1403 hours compared to15 totaling 726 hours in fiscal 12/13.

   Of the 31supporting indicators, 55% are yellow (n=5) or green (n=12), and 45% are red (n=12), with fifty five percent of indicators trending favourably. Of the 12 indicators that are red, half are showing improvement. Length of stay and avoidable admission indicators are green and red respectively with all showing improvement. Wait times of greatest concern pertain to orthopedic surgery. While there has been some slip with the percentage of services exceeding ELOS, the impact is not material. Percent ALC worsened in Q4 and not surprisingly this coupled with increased visits to ED and admissions contributed to poorer performance against the ED wait time measure and the incidence of Gridlock.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** In addition to the continued work with the Gridlock initiatives and oversight of targeted volumes/wait times, and in anticipation of C3 becoming available with completion of the carpet removal, clinical programs have been engaged in developing a proposed bed map redesign.

3. **Are we on track to meet the milestone by year end?** There has been unprecedented engagement and great support for the Gridlock VSM and resulting priority improvement processes. Three cycles have moved into a sustainability phase, an additional 2 will be fully implemented by end of Q1/15 and 5 are either well into planning or trial. There has also been improved performance with specific indicators. That said, Q4 saw an increase in activity (ED visits, admission, patient days and ALC) that impeded overall improvement.

4. **What new tactics are planned to ensure this milestone is met?** Anticipating approval of the proposed KGH bed map, which more appropriate aligns existing resources to demonstrated need and increases the total bed capacity by 11 beds, there will be new algorithms for patient flow and more precise and consistent monitoring of occupancy by unit and service. As well, a protocol to support surge with Mental Health is being developed to facilitate flow with QHC, BGH, PC and community. Evolving partnerships with the CCAC, regional partners, LTCH and Health Links are expected to support patient care for emerging population needs (behavioral support), overall patient flow and reduction of avoidable visits/admissions.

Kingston General Hospital

MS #03

			13-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	Y	Y	Y	Y	↑
		Percent of Clinical Services Meeting or Exceeding 90th Percentile Wait Time Targets (Excluding Cancer Surgery)	Y	R	R	Y	R	↑
		All Cancer Surgery Wait Time - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)	R	R	R	R	R	↑
		Percent of Cancer Care Ontario Access to Surgical Care Contract Indicators Met	R	R	R	Y	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	R	R	Y	R	↑
		General Surgical Procedures (Excluding Confirmed and Suspected Cancer Surgeries) - 90th Percentile Wait Time (Days)	R	R	G	G	G	↑
		All Paediatric Surgery - 90th Percentile Wait Time (Days)	G	G	G	Y	G	↑
		Cardiac - Bypass Surgery - 90th Percentile Wait Time (Days)	G	G	G	G	G	↓
		Cardiac - Coronary Angiography - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Cardiac - Coronary Angioplasty - 90th Percentile Wait Time (Days)	G	G	G	G	G	↑
		Orthopedic Hip and Knee Replacement Surgery - 90th Percentile Wait Time (Days)	G	G	G	Y	Y	↓
		Orthopedic Surgery (Excluding Total Hip and Knee Replacements) - 90th Percentile Wait Time (Days)	Y	R	R	R	R	↓
		Diagnostic Imaging - CT – 90th Percentile Wait Time (Days)	G	G	G	G	G	↓

35	13-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	R	R	R	R	↓
Overall - Acute Average Length of Stay Days (Based on HSAA)	G	G	G	G	G	↑
Overall - Acute Average Length of Stay vs ELOS Variance in Days	Y	G	G	G	G	↑
Percent of Clinical Services Meeting or Exceeding ELOS Target	R	Y	G	Y	R	↓
Number of Inpatient by Program Floor Assignment Patient Days Within Budget	N/A	Y	G	Y	Y	↓
Reduce the Number of Avoidable Admissions	N/A	R	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	Y	R	R	↓
Percent of Patients Admitted (from the Emergency Department) Within a Wait Time Target of < 8 hrs	Y	Y	G	Y	Y	↓
Patients Admitted from the Emergency Department (ED) with Complex Conditions - 90th percentile wait time (hrs)	R	R	R	R	R	↓
Percent of Non-Admitted Low Acuity Patients (CTAS 4&5) Treated Within a Wait Time Target of <4hrs	R	Y	Y	R	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	G	Y	Y	Y	↓

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

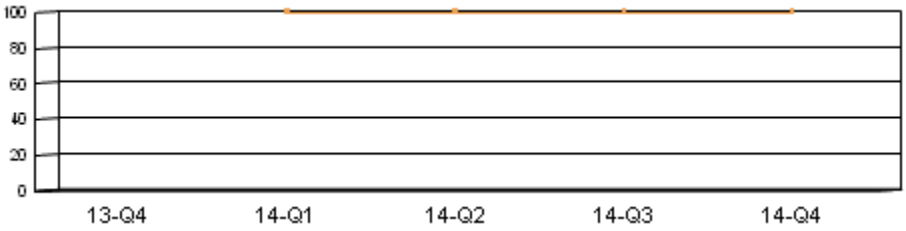
Kingston General Hospital

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

Interpretation - Patient And Business:

In Q4 there were 9 Gridlocks, ranging from 1 to 5 days in duration. This is 6 more relative to Q3 and 2 more relative to Q4 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. The improvement cycles that have been fully implemented include transfer of admission information for bed allocation; transfer of admission between units on transfer; and bed status notification. The first two are well into the sustainability phase. Improvement processes have been designed and have been launched for consultation of allied professionals; discharge predication and discharge planning. One improvement process related to on-call schedules has been IT dependent and will be fully implemented by end of Q1 F15. The Continuous Improvement approach to Gridlock issues appears to be affecting process efficiencies; however the goal of avoiding gridlocks has not yet been realized as a clinical outcome. This is explained in part due to increased ED activity and higher admissions/occupancy particularly in Medicine.

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. This has resulted in complimentary work such as developing a surge protocol for Mental Health Patient Flow and work on patient flow at a system level.

Actions & Monitoring Underway to Improve Performance:

The PFTF, as the corporate committee overseeing the Gridlock initiative, meets every two weeks with updates on the Gridlock VSM initiative and with the PDSA improvement teams. Project teams are typically interprofessional in makeup and include at least one patient experience advisor. In Fiscal 14 there have been a total of 10 initiatives launched - 3 PDSA's are complete and in sustainability mode; 1 is IT dependent and will be completed by June 14; 3 are in the pilot stage of redesign and 3 are in the 120 day design phase. All are being enabled with engagement at all levels of the organization with executive support. KGH also continues to partner with regional partners on system flow issues. (long stay patients in ED; access to LTCH or community supports for ALC patients).

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%

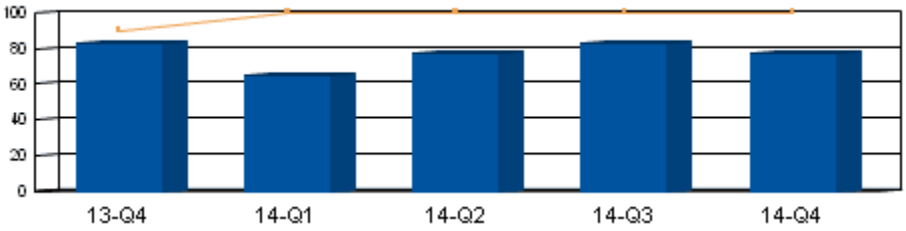
Kingston General Hospital

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

Interpretation - Patient And Business:

The Ontario government has put a plan in place to increase access and reduce wait times for most surgeries. Ontario's plan has a goal to significantly increase the number of procedures to reduce the backlog that has developed over the last decade, standardize best practices for both surgical and administrative functions in order to improve patient flow and efficiency and collect and report accurate and up-to-date data on wait times to allow better decision making and increase accountability.

Actions & Monitoring Underway to Improve Performance:

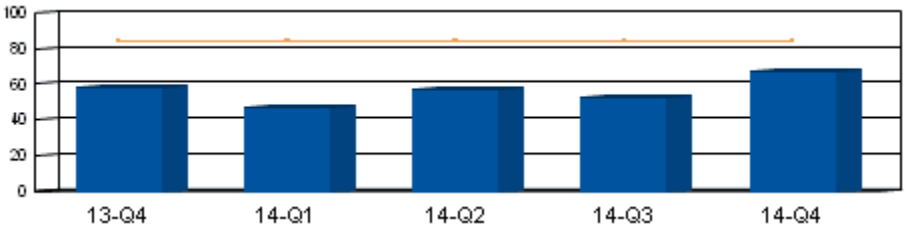
There has been a slight decrease in the number of services meeting the 90th percentile wait time target in Q4. 12 of 52 clinical areas have a status of Red with respect to meeting their wait time targets (1 general surgery; 2 gyn surgery, 2 neurosurgery, 1 oral surgery; 3 orthopedic; 2 urology, and 1 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-Q4	58	**84**
14-Q1	47	**84**
14-Q2	57	**84**
14-Q3	52	**84**
14-Q4	67	**84**

Interpretation - Patient And Business:

In Q4 this indicator continues to meet the 84 day target green corridor. There were 226 surgical oncology cases completed with a 90th percentile of 68 days in January decreasing to 61 days in March. For this quarter this service had 85% of their surgical oncology patients meeting access targets.

Actions & Monitoring Underway to Improve Performance:

SPA leadership and the Oncology Program continue to collaborate with the monitoring of this indicator. The recruitment of a Head/Neck surgeon as well as a Thoracic surgeon is anticipated to improve surgical oncology patients meeting access targets.

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

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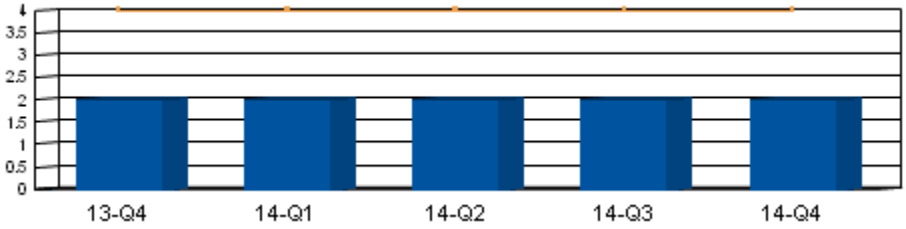
Indicator: Number of Cancer Care Ontario Access to Care Contract Indicators Met (Radiation/Chemotherapy)



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

Interpretation - Patient And Business:

At the end of Q4 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 (Q4 F14 performance is 100%). The other two indicators, Radiation Referral to first consult and Systemic Consult to start of treatment are not being met. Performance for referral to first consult in radiation dropped slightly from Q3 ending Q4 at 70.8%.

Division Heads for both Radiation and Systemic monitor access. Radiation referral to consult access is a priority for improvement with the Division Head of Radiation. Active management of radiation new case consultation wait times is underway with measures in place to add new case clinic slots in order to achieve the 14 day target. More work is required in this regard especially as the target for F15 has increased to 85%.

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.

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

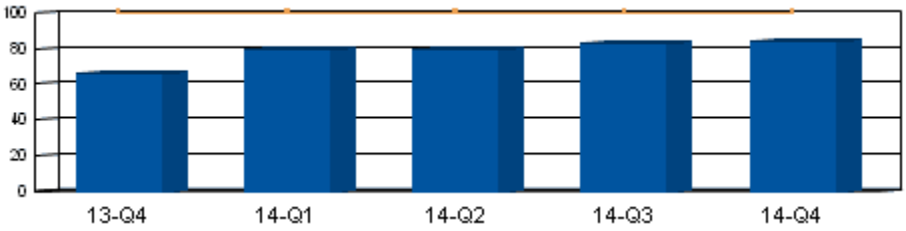
Kingston General Hospital

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-Q4	66	**100**
14-Q1	79	**100**
14-Q2	79	**100**
14-Q3	83	**100**
14-Q4	84	**100**

Interpretation - Patient And Business:

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

As of the end of Q4 F14, KGH is not meeting this target. However, steady improved performance is evident over all 4 quarters of F14. Given that the indicator performance reflects performance over the previous 12 month period, KGH has not yet achieved target performance of 90% despite exceeding this level in a number of months in Q3.

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. 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 January, February and March 2014, KGH's performance was 84%, 82% and 87% respectively. The steady gains observed since Q2 F14 have been sustained through to end of Q4. At end of Q4 F14, KGH did not meet the Cancer Care Ontario Cancer Surgery contracted target of 90%; however, these exceptional past 6 months have brought a 5% improvement in our YTD performance from 79% in Q2 to 84% in Q4.

CCO target in this indicator is 90% of cases meeting wait time target and only two out of 14 LHINS achieved 90% or better in F14 Q4 (Waterloo Wellington and Central). The Ontario average in Q4 was 85% across all priority categories.

The Cancer Surgery Wait Time Improvement Team continues to be very active in its efforts to sustain the gains seen since Q2 F14. 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. Focused attention on the GU and GYN Oncology disease sites will a priority for Q1 F15 as these two sites are showing lagging performance overall compared to the provincial access target. Lung cancer surgery was prioritized starting in F14 Q4 and will continue to be prioritized going forward.

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%

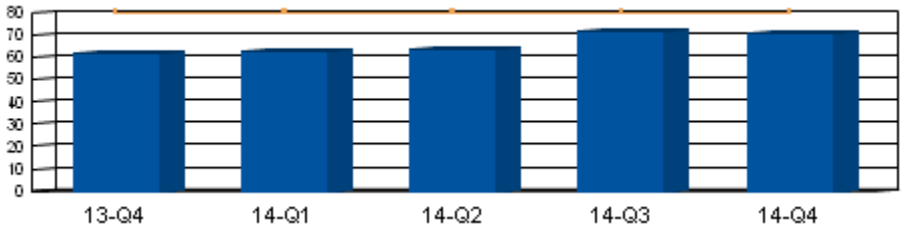
Kingston General Hospital

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-Q4	62.0	**80**
14-Q1	63.0	**80**
14-Q2	64.0	**80**
14-Q3	72.0	**80**
14-Q4	70.8	**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 Q4 F14, 70.8% of all patients referred to KGH are seen by a radiation oncologist within 14 days (compared to 72% in Q3). Improved access performance in Q4 related primarily to full staffing in the Division of Radiation Oncology as well as active management by the Division Head to ensure as many patients are seen within the 14 day target.

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:

Continued emphasis on timely access for breast cancer referrals is in place. Selected improvements are being implemented to enable meeting the 80% target for radiation referrals.

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. Target for F15 has increased to 85% of patients referred for a consultation with a radiation oncologist are seen within 14 days. This will escalate action to improve performance for this indicator.

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%

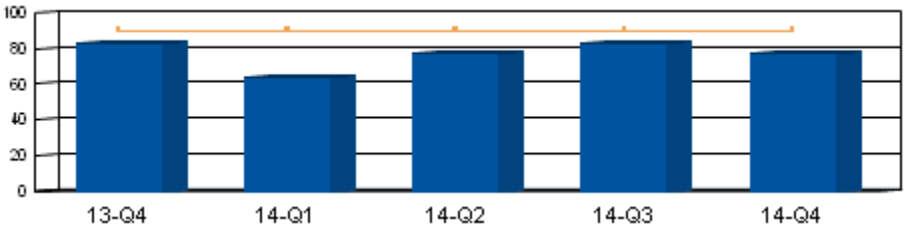
Kingston General Hospital

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

Interpretation - Patient And Business:

For Q4 the slight decrease of 6% from the previous quarter for surgical wait time meeting their 90 percentile wait time targets is influenced by the following factors: service focus on completing QBP target volumes, increase in gridlock days (9) from previous quarter (3), and 127 surgery cancellations.

The surgical oncology YTD wait time achieved 84% of the 90% target with the completion of 911 surgical cases averaging a 90th percentile of 55 days.

Actions & Monitoring Underway to Improve Performance:

Corporate initiatives focusing on reducing gridlock days, operating room cancellations and continuous management and monitoring of wait time targets should assist with improving this metric in the next quarter. The Wait Time Initiative Committee and SPA leadership continue to focus on improvement and sustainability of initiatives to improve patient care access.

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%

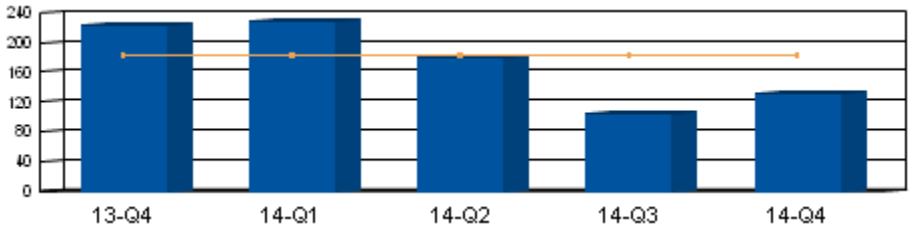
Kingston General Hospital

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-Q4	224	**182**
14-Q1	229	**182**
14-Q2	181	**182**
14-Q3	104	**182**
14-Q4	132	**182**

Interpretation - Patient And Business:

In Q4 there were 229 completed cases with 90th percentile wait times of 114 days in January increasing to 246 days in March. Within these cases there were 6 patients who waited between 243- 662 days for their surgery which also influenced median and average wait times. There were 86 operating room cancellations in this quarter that occurred for the following reasons: unexpected surgical complication previous case-17, change in patient medical condition-17, no bed available-13, gridlock called-10,insufficent time remaining-6, case substitution-5,emergency case inserted-4, surgeon unavailable-2, enviromental-1 and patient related (patient no show, patient non compliant-1, patient not NPO-1, patient refused procedure-1, patient unavailable-2).

Actions & Monitoring Underway to Improve Performance:

The wait times continue to be tabled on the SPA program council as well as the corporate Wait Time Committee. The OR Cancellation Task group is working at opportunities to improve avoidable cancellations to improve patient surgical care access.

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

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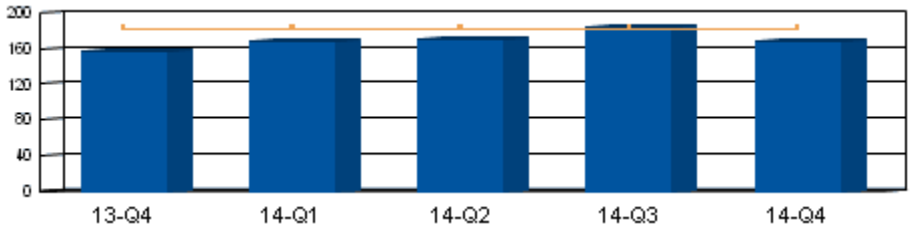
Indicator: All Paediatric Surgery - 90th Percentile Wait Time (Days)



	Actual	Target
13-Q4	157	**182**
14-Q1	167	**182**
14-Q2	170	**182**
14-Q3	183	**182**
14-Q4	168	**182**

Interpretation - Patient And Business:

For Q4 there were 385 inpatient and outpatient pediatrics surgical cases completed at KGH and HDH sites. The overall 90th percentile wait time for January was 176 days decreasing to 153 days in March. Within the completed cases there were 11 pediatric patients that waited between 184-501 days for their surgery. Pediatric surgical activity for this quarter is the following:

General Surgery (40 cases):
There were 40 pediatric patients who received surgery within the 182 day target. There are 14 cases on the waiting list with one case already over the target date.

Dentistry (58 cases):
There were 56 pediatric patients who received surgery within the 182 day target and 2 patients who waited 328 and 371 days respectively for their surgery. There are currently 116 pediatric patients on the waiting list with 55 of them already over the 182 day target.

Orthopedic Surgery (67 cases):
For Q4 there were 65 pediatric patients who received their surgery within the 182 day target and 2 patients who had waited 297 and 371 days. There are 68 pediatric patients on this waiting list with 34 already over the 182 wait time target.

Plastics (15 cases):
There were 15 pediatric patients who had surgery within the wait time target. There are 6 patients on the wait list below the wait time target.

Urology (14 cases):
There were 11 pediatric patients who received surgery within the 182 wait time target and 3 patients who waited between 200 and 324 days for their surgery. There are 26 patients currently on the wait list with one patient already over the wait time target.

Otolaryngology (157 cases):
There were 153 pediatric patients who received their surgery within the wait time target and 4 patients who had to wait between 184 and 501 days for their surgery. There are 129 pediatric patients on the waiting list with 53 patients already over the 182 wait time target.

Gynecology (1 case):
There was only one pediatric patient surgery this quarter that was well within the wait time target. There are currently 2 patients on the waiting list who are below the wait time target.

Ophthalmology (31 cases):
All 31 pediatric patients received their surgery within the 182 wait time target. There are currently 23 pediatric patients waiting on the wait list with 7 patients already over the wait time target.

Actions & Monitoring Underway to Improve Performance:

Pediatric wait times continue to be monitored by the SPA program council and the corporate Wait Times 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

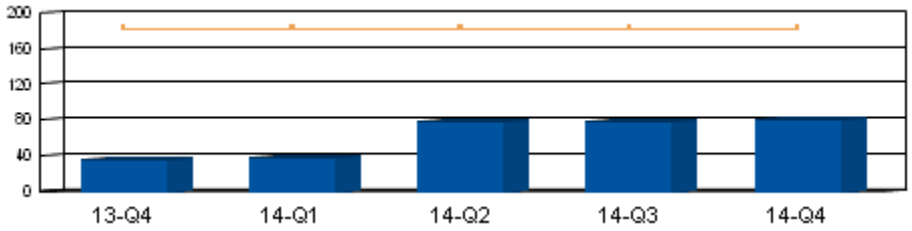
Kingston General Hospital

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-Q4	35	**182**
14-Q1	37	**182**
14-Q2	79	**182**
14-Q3	79	**182**
14-Q4	81	**182**

Interpretation - Patient And Business:

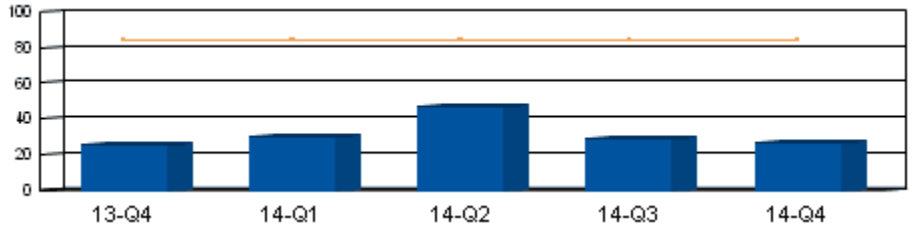
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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-Q4	26	**84**
14-Q1	30	**84**
14-Q2	47	**84**
14-Q3	29	**84**
14-Q4	27	**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

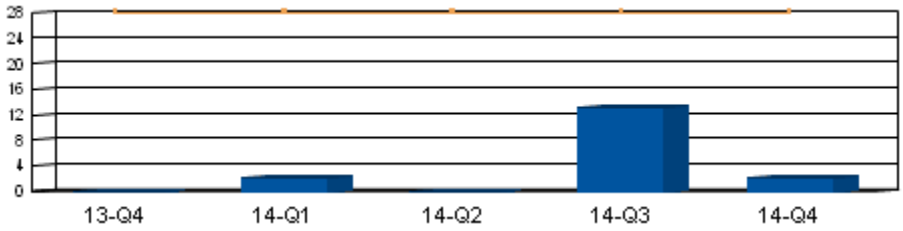
Kingston General Hospital

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-Q4	0	**28**
14-Q1	2	**28**
14-Q2	0	**28**
14-Q3	13	**28**
14-Q4	2	**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

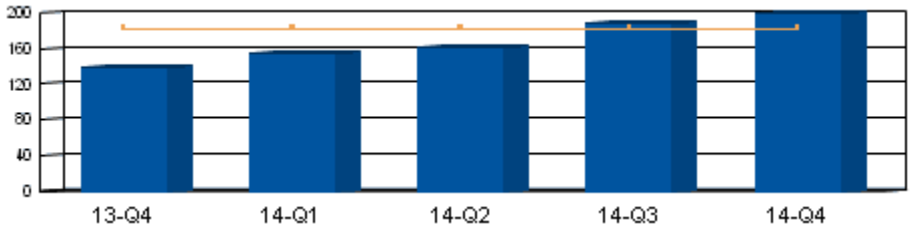
Kingston General Hospital

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-Q4	139	**182**
14-Q1	154	**182**
14-Q2	161	**182**
14-Q3	188	**182**
14-Q4	200	**182**

Interpretation - Patient And Business:

For Q4 this indicator was strongly influenced by the QBP targeted volumes requiring the slowdown of surgical activity (increasing wait times) due to the limited assigned funded volumes and the inability to obtain any additional volumes from the SELHIN.

For hip replacement surgery there were 35 cases competed in this quarter with a 90th percentile of 153 days in January increasing to 195 days in March. The YTD funded target volume of 205 had been exceeded by 10 patient cases. There are currently 181 patients waiting for hip replacement surgery with over 100 already exceeding the 182 day wait time target.

For knee replacement surgery there were 143 cases completed with a 90th percentile of 186 days in January decreasing to 153 days in March. Included in these cases were 4 patients who had waited between 290-417 days for their surgery. The YTD targeted funded volume of 338 cases was also exceeded by 4 cases. There are currently 204 patients waiting for knee replacement surgery and over 106 are already over the 182 day waiting list target.

Actions & Monitoring Underway to Improve Performance:

SPA leadership continues to work on corporate initiatives to improve patient access care by reducing avoidable OR cancellations, improving bed flow. Working with the external partners to improve access to surgical volumes, and the Division of Orthopedics to improve the management of surgical wait lists.

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

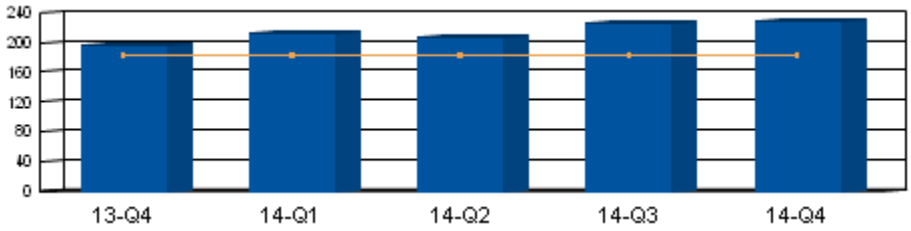
Kingston General Hospital

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-Q4	196	**182**
14-Q1	212	**182**
14-Q2	206	**182**
14-Q3	227	**182**
14-Q4	228	**182**

Interpretation - Patient And Business:

In Q4 there were 287 completed surgical cases with a 90th percentile wait time of 219 days in January increasing slightly to 244 days in March. Included in these cases were 7 patients who had waited between 222-444 days for their surgery. Also influencing this wait time were 36 operating room cancellations (gridlock-17, no bed-4, surgeon unavailable-3,anesthesia unavailable -4, patient no show-2,unexpected complication previous case-1, office incorrectly booked-1, previous case ran over time-1, patient change in medical condition-1, emergency case substitution-1, surgery no longer required).

There are currently 588 patients waiting on the orthopedic list with 298 already exceeding the 182 day target.

Actions & Monitoring Underway to Improve Performance:

Corporate Gridlock initiatives (OR Cancellation Task working group, Discharge Planning working group) should assist with improving this metric. SPA leadership and the Division of Orthopedics are working collaboratively to ensure wait times are being monitored and managed to address patient care access.

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

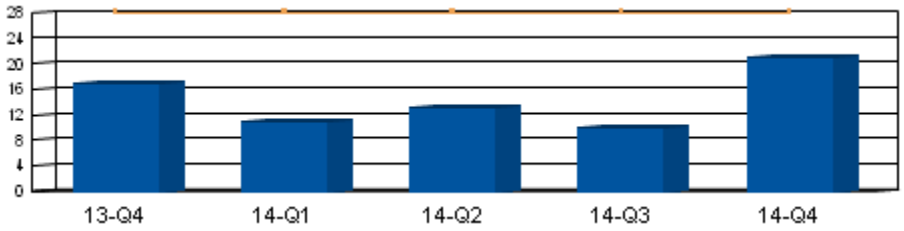
Kingston General Hospital

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-Q4	17	**28**
14-Q1	11	**28**
14-Q2	13	**28**
14-Q3	10	**28**
14-Q4	21	**28**

Interpretation - Patient And Business:

KGH CT generally has a wait time below 15 days. This 4th quarter has seen a spike in wait time to 21 days. Early review and investigation seems to lead to errors in documentation where "timed" studies are being captured in the wait time data as opposed to being exempt.

Actions & Monitoring Underway to Improve Performance:

KGH deals mainly with emergent and urgent CT cases for the Emergency Department and the Inpatient Units. The other large patient population is the "timed" cases which are predominantly Cancer Center patients who require CT follow up at specific times during their treatment regime. For example: A patient will have treatment during January and a CT is requested for the month of April to determine the patient's response to treatment. The requisition for the patient's exam will arrive in the department in February but we are not to book it until the end of April. They are considered "timed" exams and should not be counted in our wait time numbers.

The LHIN has set a goal for us to have a wait time of less than 15 days based on our patient population. We strive to achieve that every quarter.

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

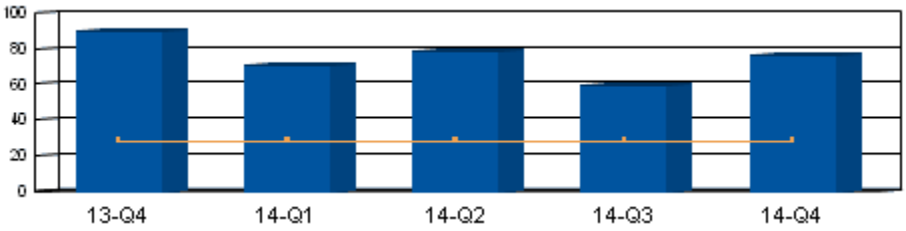
Kingston General Hospital

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-Q4	90	**28**
14-Q1	70	**28**
14-Q2	78	**28**
14-Q3	59	**28**
14-Q4	76	**28**

Interpretation - Patient And Business:

The MRI wait time is a result of the large volume of requests that KGH must manage on a monthly basis. We are unable to accommodate all the requests in the preferred time frame. KGH has a high number of Priority 1 and 2 requests which push out the Priority 3 and 4 bookings contributing to a long wait time.

This is frustrating for both patients and referring physicians. It also increases the anxiety of the patient as they must wait longer than ideal for diagnostic results. Patients also suffer the frustration and inconvenience of being cancelled at the last minute if they are a Priority 3 or 4 exam when the department has a higher than usual number of Priority 1 and 2 requests.

It is a difficult working environment for the booking clerks, the technologists and the physicians. It does not contribute to a positive patient experience and at times delays diagnosis and treatment.

Actions & Monitoring Underway to Improve Performance:

A business plan has been created and a request for approval to purchase and install a second magnet at KGH has been forwarded to the LHIN. The LHIN has supported the plan. The request is now with the Ministry of Health. KGH is waiting final approval. When approval is received, KGH will need to fund raise approximately six million dollars for the purchase of the magnet and room construction.

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

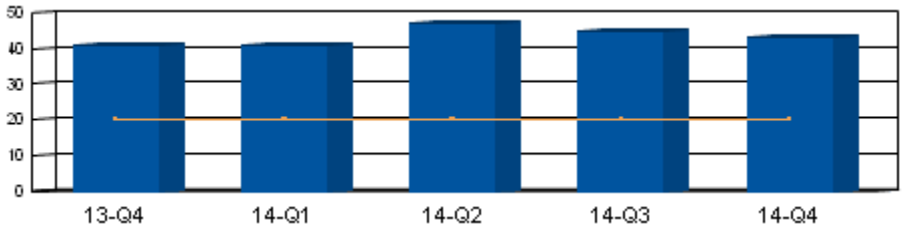
Kingston General Hospital

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-Q4	41	**20**
14-Q1	41	**20**
14-Q2	47	**20**
14-Q3	45	**20**
14-Q4	43	**20**

Interpretation - Patient And Business:

In November of 2013 convalescent care beds and restorative rehabilitation beds (slow stream rehab) became available to the region. Although these beds are not net new beds, they are two previously unavailable destinations for our ALC patients. As a result, ALC patients have more timely access to beds in the community than in the past i.e. previously they would be waiting for access to long term care facilities. The average number of ALC patients in Q4 remain well over the target number, but the numbers of patients waiting for LTC has somewhat shifted towards other locations.

ALC patients waiting for access to long term care facilities remain the largest population with the longest wait times for discharge to the community. Concerns continue to be raised regarding the major barriers to admission including: demand for beds in excess of the regional supply and a new funding formula recently put in place for long term care homes that resulted in the homes not accepting patients onto their waiting lists; claiming inadequate funding to meet the patient's needs. Reductions in long term care homes' acceptance of patients with high needs (equipment/supplies) has further reduced access to the already limited number of beds in the community.

Actions & Monitoring Underway to Improve Performance:

Familiarity with processes for gaining access to the new convalescent care and restorative rehab beds is improving utilization of these resources. This will continue to improve patient flow as we avoid designating patients ALC for long term care.

Concerns regarding barriers to long term care homes due to high patient need (equipment/supplies) are discussed regularly with CCAC, the SELHIN and the Ministry of Health and Long Term Care. At this time information is collected and submitted to the Ministry via CCAC on a case by case basis.

Other areas being addressed include access to destinations for patients with special needs specific to behaviours associated with dementia. The introduction of the behavioural support teams from Providence Care is assisting with planning and supporting patients as they transition to the long term care homes. This collaboration has resulted in more successful transfers to long term care i.e. fewer returns to hospital due to the long term care homes' inability to manage the behaviours.

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

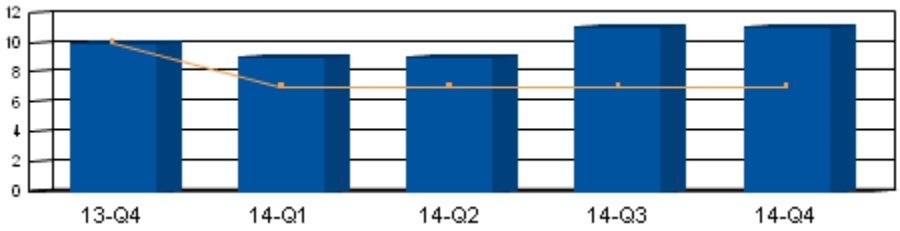
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Percent ALC Days



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

Interpretation - Patient And Business:

The total number of ALC days is influenced by both the number of ALC patients and their ALC-specific lengths of stay. A high number of ALC days generally reflects the lack of timely access to destinations outside of KGH once the patients' acute care stay is complete. The provincially mandated ALC discharge destinations include: long term care homes, retirement homes, rehabilitation, home, supportive/assisted living, complex care, convalescent care, and mental health.

The Q4 result of 11% indicates that, on average, there are more than 40 inpatients at KGH whose acute care stay is complete and who are waiting for access to one of the destinations listed above.

Actions & Monitoring Underway to Improve Performance:

Activity for the coming year will focus on two areas to address this indicator: the number of patients who are admitted to KGH and designated ALC within 72 hours of admission, and the number of ALC patients who have lengths of stay in excess of 100 days.

KGH continues to engage with patients and families and with regional partners to address the barriers to discharge to allow for timely access to community-based destinations.

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%

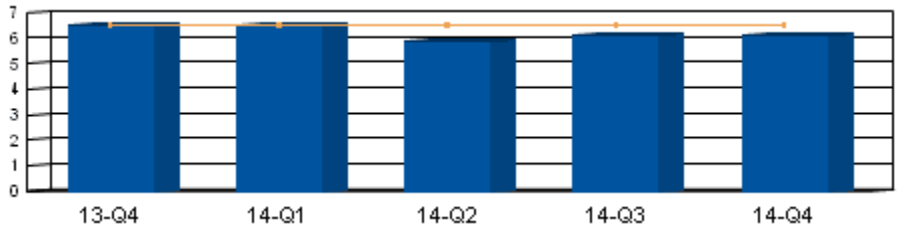
Kingston General Hospital

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-Q4	6.5	**6.5**
14-Q1	6.5	**6.5**
14-Q2	5.9	**6.5**
14-Q3	6.1	**6.5**
14-Q4	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 overall average length of stay for Q4 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

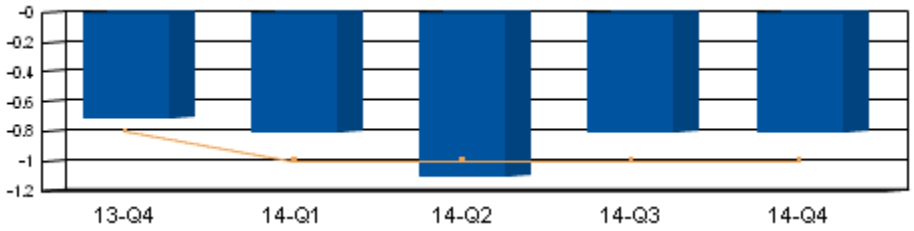
Kingston General Hospital

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

Interpretation - Patient And Business:

A positive trend in overall performance continued in Q4. The 0-.8 day variance for Q4 (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 are 6 of 18 services that did not achieve expected length of stay in Q4. The services of General Surgery, Haematology, Nephrology, Neurology, Neurosurgery, and Orthopedics.

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

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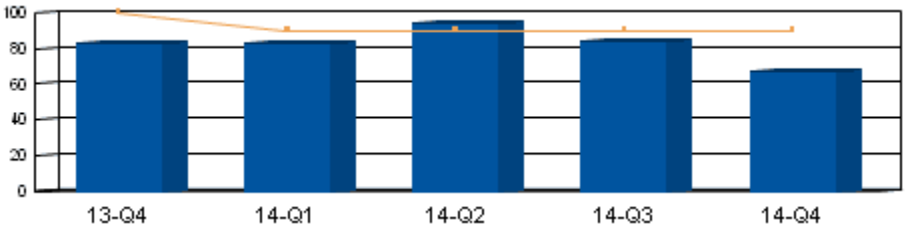
Indicator: Percent of Clinical Services Meeting or Exceeding ELOS Target



	Actual	Target
13-Q4	83	**100**
14-Q1	83	**90**
14-Q2	94	**90**
14-Q3	84	**90**
14-Q4	67	**90**

Interpretation - Patient And Business:

As of Q4 (fiscal 13/14), 67 percent of services (12 of 18) are achieving (or outperforming) their expected length of stay. Although we continue to slip in the quarter, the 6 services that are at or slightly above their expected don't represent a material difference with respect to total patient days. The services are General Surgery, Haematology, Nephrology, Neurology, Neurosurgery, and Orthopedics.. It is a well understood challenge and improvement cycles are ongoing.

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%

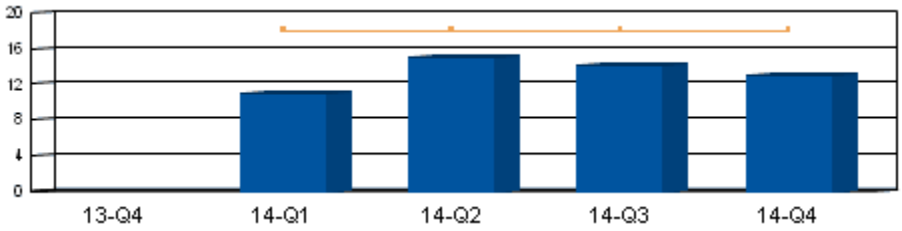
Kingston General Hospital

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-Q4		
14-Q1	11	**18**
14-Q2	15	**18**
14-Q3	14	**18**
14-Q4	13	**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 other programs by off servicing patients to units outside of the program. There were 9 Gridlocks in Q4 which is the highest per quarter since the inception of the code. This is attributed to increased visits to ED, increased admissions, increased ALC which affects turnover of beds and patient access. While Medicine continues to be the program that experiences greatest challenge with clinical surge, in Q4 there was similar challenge with the Mental Health program. 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, and alignment of efforts to Gridlock VSM. Review of the Corporate Bed Map has resulted in proposed bed map. Next steps to review logistical impact to budget and staffing is underway - with goal of decision and implementation by Q2.
In response to a variety of discharge challenges, there are initiatives underway at the system level to support improved patient flow and avoidance of admissions/readmissions. These involve a KGH led PDSA with readmission; collaboration with Health Links and a new task team focusing on access and flow with LTCH's.

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

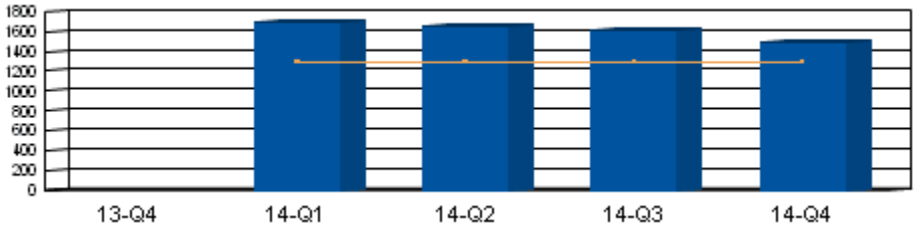
Kingston General Hospital

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-Q4		
14-Q1	1,701	**1292**
14-Q2	1,661	**1292**
14-Q3	1,610	**1292**
14-Q4	1,500	**1292**

Interpretation - Patient And Business:

While demonstrating a downward trend (12% over 3 quarters), the indicator is not yet near an acceptable corridor of performance (remains 16% above the target). As part of the Gridlock VSM initiative, and in Q3/Q4 improvement cycles focused on eliminating delay with assessments and decision making of patients in ED, and with discharge prediction and planning. These are believed to be having impact on the number of avoidable admissions by reducing admissions, and by better engaging care team, families; and community based supports in enabling successful transitions to community or other locations. 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 a collaborating partner with 2 Health Link teams (Kingston and Rural Kingston) as they work on ways to focus on high risk populations and supporting ways of providing support in the home and earlier interventions in the community. The objective is optimal health and reduced likelihood of need for ED or readmission.

Actions & Monitoring Underway to Improve Performance:

In Q1 2015, KGH will launch an improvement cycle focused on internal opportunities to address avoidable admissions/readmissions with membership that in addition to the predictable complement of KGH clinical team members and advisor will include the Health Links, family physicians and CCAC. This will also complement the work occurring at the regional and system level with Health Links, with the mental health redesign, and in partnering with LTCH to determine ways to address needs of populations with special needs (behavioural support).

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 Red: >1550/qtr Yellow: 1422-1550/qtr Green: <1421/qtr

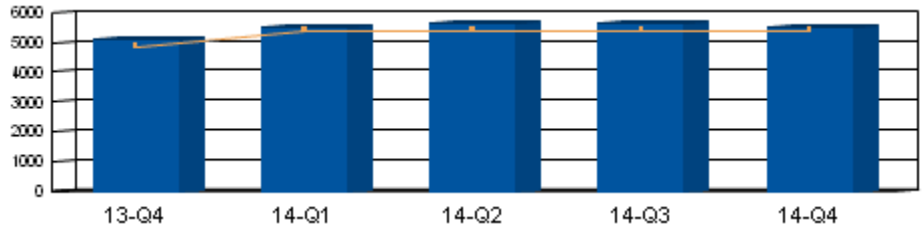
Kingston General Hospital

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-Q4	5,130	**4850**
14-Q1	5,514	**5398**
14-Q2	5,671	**5398**
14-Q3	5,631	**5398**
14-Q4	5,494	**5398**

Interpretation - Patient And Business:

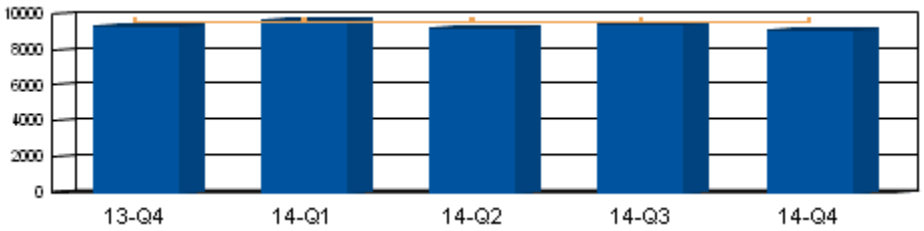
This indicator has been status "green" for the past 5 quarters and requires no progress comment.

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-Q4	9,272	**9556**
14-Q1	9,609	**9579**
14-Q2	9,140	**9579**
14-Q3	9,407	**9579**
14-Q4	9,071	**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

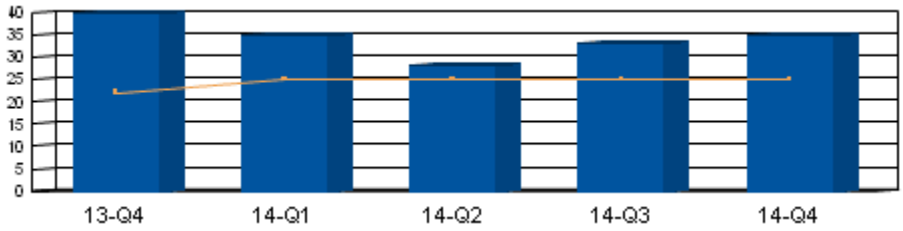
Kingston General Hospital

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

Interpretation - Patient And Business:

The Q4 result of 35 hours is 10 hours longer than the 25 hour target. Ninety percent of all patients admitted through the ED wait up to 35 hours to be transferred to an inpatient bed. Ten percent wait longer than this. Based on Q4 admission volumes of 2675, 268 patients waiting longer than 35 hours in the ED for an inpatient bed. This has a negative impact on the ability to see, assess and treat other patients within the recommended time.

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. Strategy for this year included identifying top sources of gridlock with recommendations on how to address opportunities identified. 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. The Patient Flow Task Force has oversight of these initiatives and receives updates twice a month. OPPU has been used frequently before and during Gridlock to decant admitted patients from the ED to create capacity. This has a negative impact on activity in other areas such as endoscopy and interventional radiology.

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

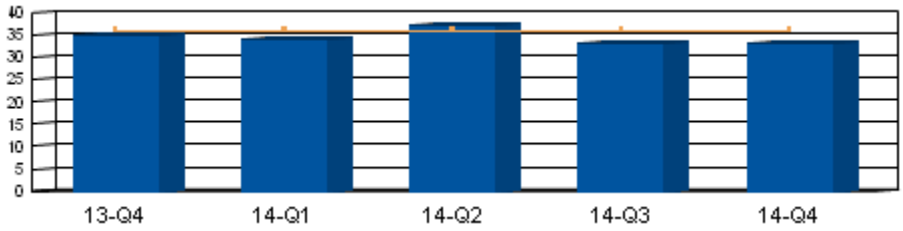
Kingston General Hospital

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

Interpretation - Patient And Business:

In Q4, 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. Q4 had an admission rate of 20% of all ED visits for a total of 2675 admissions.
Emergency Department admitted patient volumes are above target by 259 admissions this quarter and over by 1379 YTD. Inpatient bed days are 1196 days in Q4.

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%

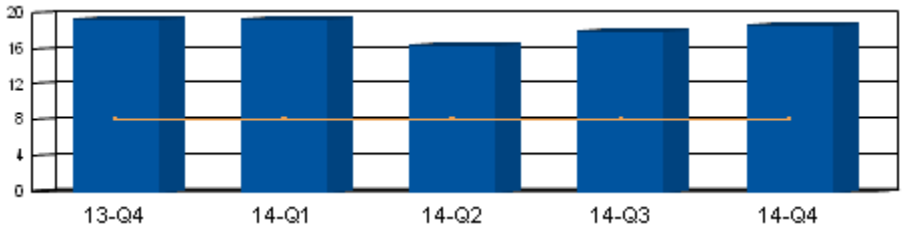
Kingston General Hospital

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-Q4	19.3	**8**
14-Q1	19.3	**8**
14-Q2	16.3	**8**
14-Q3	18.0	**8**
14-Q4	18.7	**8**

Interpretation - Patient And Business:

ED wait times at the 90th percentile for patients admitted with complex conditions is 18.7 hours in Q4. Nine of ten patients in this category are moved to an inpatient bed within 18 hours of arrival to the department while 10 percent wait longer than 18.7 hours. Inpatient days in the ED are at 1196 days in Q4. This is a YTD total of 4801 bed days for admitted patients in the ED or the equivalent of an average of 13 beds.

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

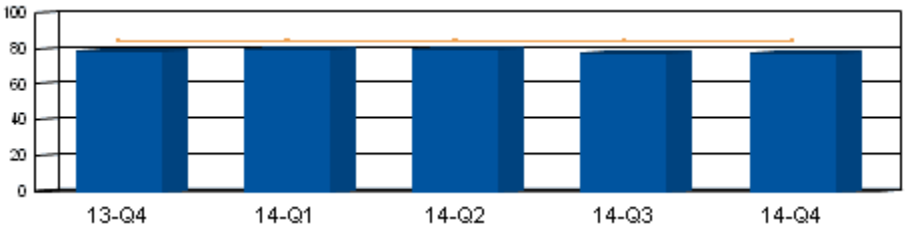
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on Q4 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 24% of all ED visits. The 90th percentile for this category is 5.8 hours which means that 90% of patients are discharged within 5.8 hours. The PIA time (physician initial assessment) is under 2.5 hours over 90% of the time indicating that diagnostics and treatment makes up the remainder of the wait time.

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 group has put together a value stream map of flow through fast track and has identified opportunities to enhance flow. The addition of a phlebotomist and use of medical directives is helping to reduce delays related to turn-around times for lab results.
The Emergency Department Information System (EDIS) is a valuable tool that allows for continuous monitoring of ED wait times and patient flow in real time. Computerized Provider Order Entry is the final phase of the EDIS project and will be live in the fall of 2014.

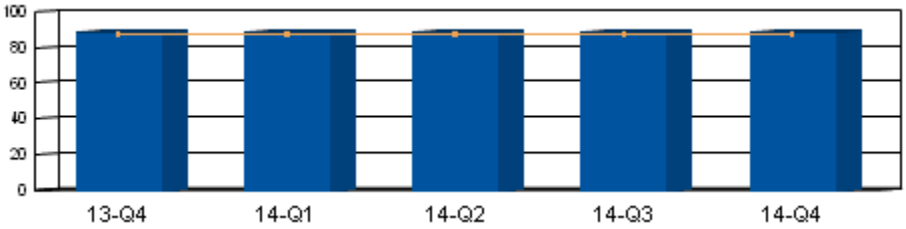
Definition: DATA: Decision Support COMMENTS: Julie Caffin SUPPORTING INDICATOR

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%

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

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%

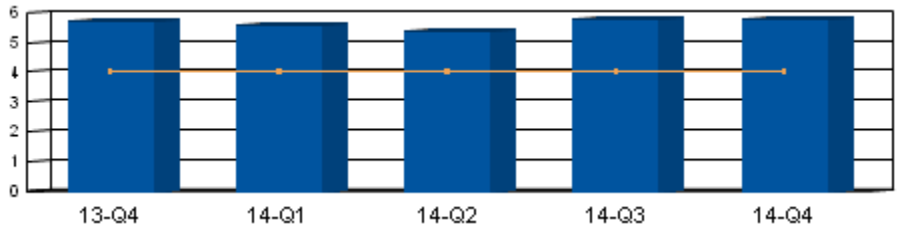
Kingston General Hospital

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

Interpretation - Patient And Business:

Based on Q4 results, the ED is failing to meet the 90th percentile wait time target of 4 hours for patients presenting with minor or uncomplicated conditions. Ninety percent of patients in this category had a total length of stay longer under 5.8 hours. Based on Q4 volumes, 2825 patients in this category had a total length of stay (LOS) of under 5.8 hours while 314 patients had a longer LOS. 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. Flags have been added to EDIS to alert staff of pending breaches. A project manager has been assigned 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. A change to the physician schedule/assignment has been proposed to better align with patient arrival times.

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

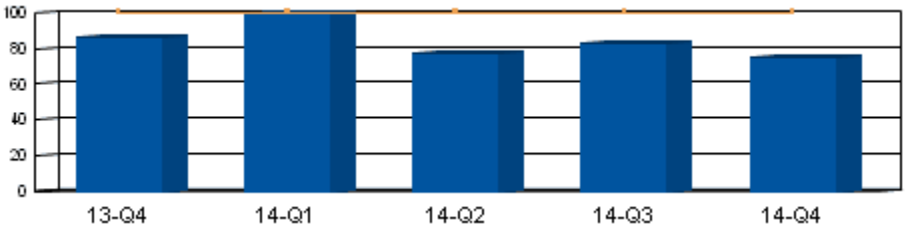
Kingston General Hospital

MS #03

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

The top sources of GRIDLOCK are addressed.

Indicator: Percent of Wait Time Contracted Volumes Achieved



	Actual	Target
13-Q4	86	**100**
14-Q1	100	**100**
14-Q2	77	**100**
14-Q3	83	**100**
14-Q4	75	**100**

Interpretation - Patient And Business:

As of Q4, 9 of 12 Wait Time Contracted volumes were met. The three that were not achieved were general surgery anorectal (missed by 4 cases), scoliosis surgery (missed by 4), and reconstructive maxiofacial surgery (missed by 5 cases).

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?** This priorities consisted of developing and implementing a workplan that involved selecting 5 corporate standards for PFCC; facilitating supportive communication and education; developing a means of auditing and reporting adoption of standards. The workplan was fulfilled in Q3 with auditing beginning in December. Results demonstrate that in Q4 4 of the 5 standards (80%) have achieved or exceeded the threshold of 80% (Use of patient whiteboard – 85%; communication – 88%; hourly rounding- 89% and patient led feedback forums – 89%) The one standard falling below was ID badges at 76%.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** The focus in the past quarter has been on ensuring awareness and completion of the auditing process, and following up on the reported results with communication and education as needed.

3. **Are we on track to meet the milestone by year end?** The workplan was achieved and the target was met.

4. **What new tactics are planned to ensure this milestone is met?** The auditing/reporting/responding cycle will continue to ensure that there is targets are met and sustained in each area and with all categories of staff. The primary focus in the next year will the implementation of the HEART program as a customer service/empathetic communication strategy. This will form the basis for future assessment of the PFCC standard for communication. The first train the trainer education session is scheduled for June 26/27th with further roll out to 500 staff in Q3 and Q4.

Kingston General Hospital

MS #04

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

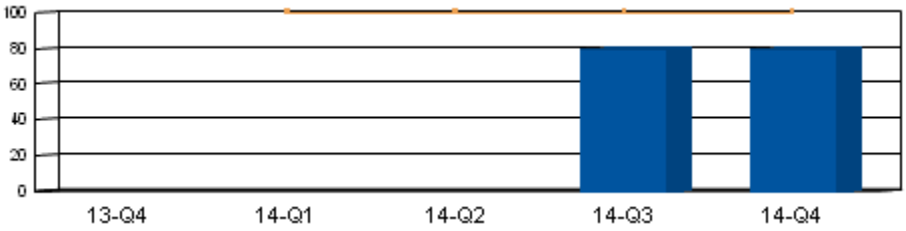
Kingston General Hospital

MS #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-Q4		
14-Q1		**100**
14-Q2		**100**
14-Q3	80	**100**
14-Q4	80	**100**

Interpretation - Patient And Business:

Corporate percentages all meet the 80% goal except for ID badges which is at 73% when all staff and physicians are included. When staff and physician results are looked at individually staff have a 79% compliance rate with physicians at 58%. Individual units and services are performing well but not all are meeting the 80% goal in each of the 5 standards. Online learning module is active.

Actions & Monitoring Underway to Improve Performance:

Directors and managers receive monthly reports on their staff's compliance and support improvement where needed. 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 (**completed**); *a KGHRI magazine-style report summarizing the accomplishments of our first three years as a Research Institute (**expected to roll out by end of May**).* KGHRI strategic plan put on hold temporarily due to joint venture moving at a quicker pace **(ongoing)** . *Black Tie Video for Centre for Patient Oriented Research (CPOR) fundraising (**completed**)*. Applications to Canadian Foundation for Innovation for funds to contribute to creation of CPOR (**completed**) .

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

Planning for joint venture with Queen's Faculty of Health Sciences and hospital partners: *monthly meetings with CEOs, Dean and key research stakeholders,(**ongoing**)*; agreement reached on many key issues (**completed**), *needs assessment (**completed**);* asset map (**completed**); *agreement reached with Queen's to proceed to RFP for consultants to create joint venture constitution, structure, governance, and operational plan (**completed**)* .

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:

- Video profiles of new clinician scientists
- F2014 Research Report (annual event)
- KGHRI: the first three years
- KGHRI branding and website development.
- Communication/marketing plan development
- Research showcase with SEAMO and other public research forums being planned
- Functional planning for CPOR

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

- Prepare and issue RFP for development of a business and structural plan for joint venture
- Eliminate duplication of research reporting activities across FHS and KGH
- Engage HDH and PC in supporting research infrastructure

Kingston General Hospital

MS #05

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

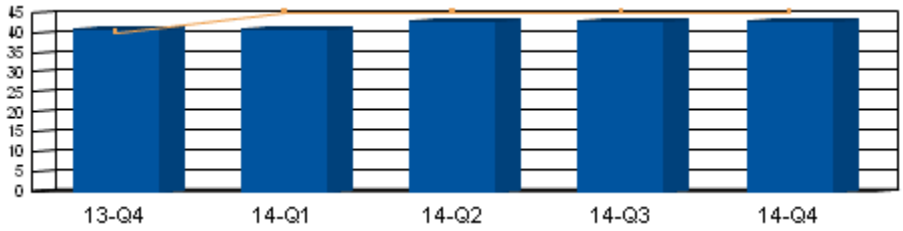
Kingston General Hospital

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

Interpretation - Patient And Business:

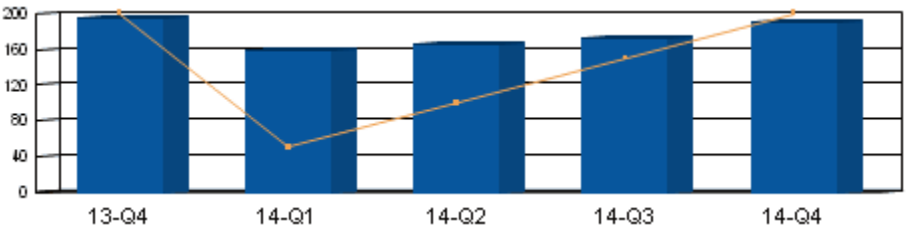
The KGH Research Annual Report was released in November 2013. The data for percent increase in research funds was recorded in Q2. Real F2013 data was used for reporting of F2014 data for this performance indicator since real figures for F2014 will not be available until September 2014. 95% of the data 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-Q4	195	**200**
14-Q1	158	**50**
14-Q2	165	**100**
14-Q3	173	**150**
14-Q4	190	**200**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the fourth quarter (Q4).

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

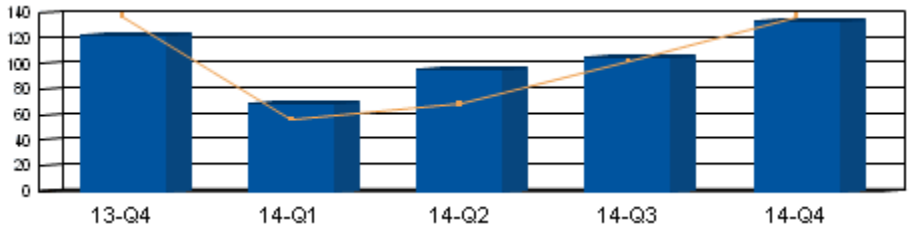
Kingston General Hospital

MS #05

Cultivate patient oriented research

Externally funded research at KGH has increased to 45%

Indicator: Clinical Trials Generating Revenue



	Actual	Target
13-Q4	123	**137**
14-Q1	69	**56**
14-Q2	95	**68**
14-Q3	105	**102**
14-Q4	134	**137**

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH reached its targets by the end of the fourth quarter (Q4).

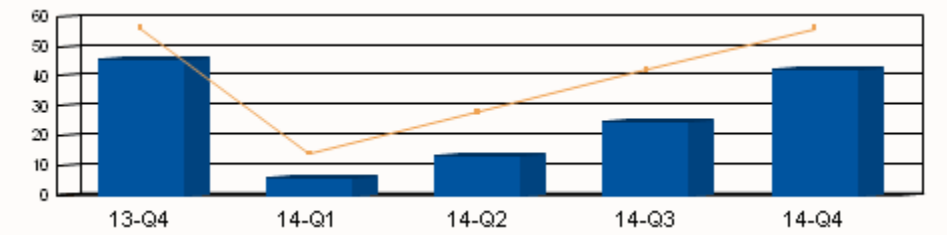
Definition: DATA: Veronica Harris-McAllister COMMENTS: Veronica Harris-McAllister SUPPORTING INDICATOR

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

Interpretation - Patient And Business:

Patient Perspective: Based on the fiscal year to date, patients had access to new clinical trials at KGH during Q4.

Business Perspective: Based on the fiscal year to date, KGH is behind target by the end of the fourth quarter (Q4). As per our Agreement Affiliation with Queen's University, clinical trial contracts, agreements and grants are administered by the University Research Services' Contracts Office. Over the past fiscal year, positions within the Queen's Contracts Office were eliminated due to financial constraints at the university.

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

Green

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?

The indicator is green based upon a protocol has been adopted for all 3 improvement priorities:
1. Reduce the number of patients waiting for transfer to other facilities – transportation agreement in place; working with regional partners/SECHEF leaders
2. Reduce 30 day readmissions – e-discharges; value stream mapping completed
3. QBP are effectively delivered –identification of team members to analyze coding and case costing data

On average 2 patients/day throughout Q4 were awaiting transfer out of KGH to a regional facility or a hospital outside our LHIN. This is a 10% improvement from Q3 (2.3 patients/day). Readmissions to any facility or only back to KGH was 17%. This equates to an average of 10 patients/day being readmitted within 30 days of discharge.

Of the 24 indicators within the milestone 19 are green/yellow (76%) and 5 are red. Three of the five reds were within the 5 QBP indicators. Two (stroke and vascular) are urgent/non-elective clinical problems that are not controlled to the targeted volume (ie we will always treat the patient). Hip and knee volumes although elective in nature, had province wide target issues with hip targets under estimated and knee significantly over estimated (ie not enough hip funding and too much knees funding relative to the need to do hips). Discussions have been frequent with the SE LHIN. Volume and funding between QBP pools has been allowed this fiscal year.

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)

- transportation agreement in place; working with regional partners/SECHEF leaders
- e-discharges data to departments; value stream mapping completed
- Development and initial implementation of a QBP Steering Committee

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

The milestone was reached at end of fiscal.

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

A department refocus on e-discharge summaries
Implementation of a QBP Steering Committee to guide new programs as they come online. Alignment to tactics outline in the Integrated Corporate Plan and QIP 2015.

Kingston General Hospital

MS #06

			13-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	Y	Y	G	G	↑
		The Number of Patients Waiting for Transfer to Other Facilities is Reduced by 50%	N/A	R	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	R	R	Y	Y	↑
		QBP (Quality Based Procedure) - COPD	N/A	Y	Y	Y	G	↑
		QBP (Quality Based Procedure) - Heart Failure (CHF)	N/A	Y	Y	Y	Y	↑
		QBP (Quality Based Procedure) - Primary Hip & Knee Replacement Volume	G	Y	Y	Y	R	↑
		QBP (Quality Based Procedure) - Stroke	N/A	Y	Y	Y	R	↑
		QBP (Quality Based Procedure) - Vascular	N/A	Y	Y	Y	R	↓
		Ambulatory Care Volumes	G	G	G	G	G	↑
		Cardiac - Angiography Volumes	G	G	G	G	G	↑
		Cardiac - Angioplasty Volumes	Y	Y	Y	Y	G	↑
		Cardiac - Bypass Volumes	G	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	↑

73	13-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	Y	Y	Y	R	G	↑
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 ↓

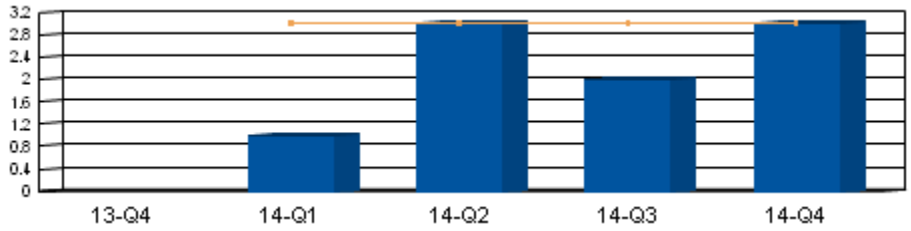
Kingston General Hospital

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

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

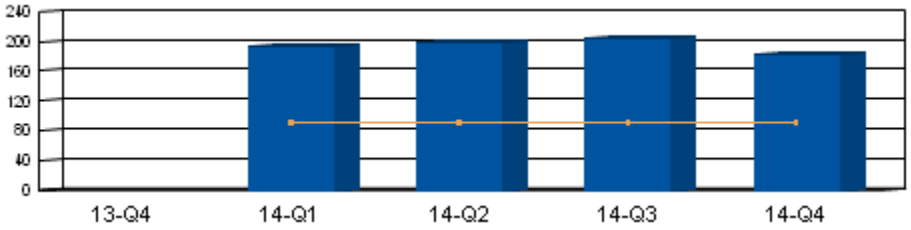
1. Patient Repatriation Transfer: Transfers to intra-LHIN hospitals requires frequent prompting to initiate activity. Upcoming transportation agreement is expected to help expedite and simplify transfers.
2. 30 day readmission rates: VSM exercise is underway
3. QBP: Teams are beginning to meet and analyze coding and case costing data

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-Q4		
14-Q1	194	**90**
14-Q2	199	**90**
14-Q3	205	**90**
14-Q4	183	**90**

Interpretation - Patient And Business:

Results for Q4 are very encouraging and in fact are the best of the entire year. A combination of the new repatriation policy via the LHIN's SECHEF (leadership group) and a new non-urgent transportation system finally appears to be having a positive 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

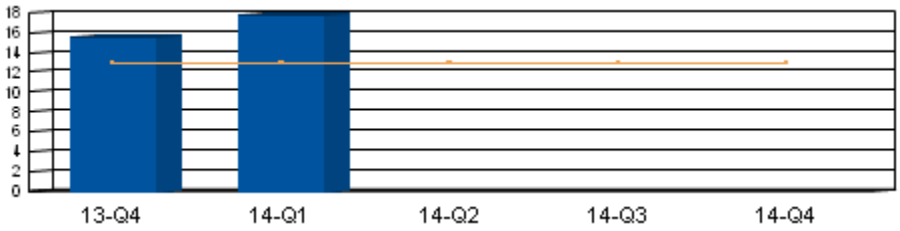
Kingston General Hospital

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-Q4	15.6	**12.9**
14-Q1	17.8	**12.9**
14-Q2		**12.9**
14-Q3		**12.9**
14-Q4		**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:

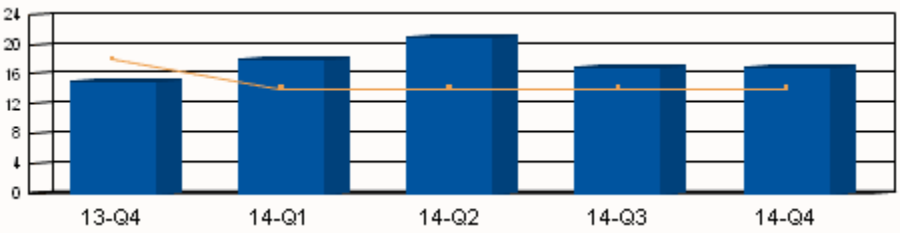
The data is supplied to KGH from the MOH and generally will be 3 quarters behind. The current rate of 17.8 is above the target of 12.9 but maintaining yellow status. Readmission rates remain a focus for fiscal 14/15 with a complete VSM exercise planned for Q1 fiscal 14/15.

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-Q4	15	**18**
14-Q1	18	**14**
14-Q2	21	**14**
14-Q3	17	**14**
14-Q4	17	**14**

Interpretation - Patient And Business:

Readmission rates remain a focus for the organization. A formal value stream mapping (VSM) exercise focusing on readmissions is being initiated and will include regional partners as well as CCAC.

Actions & Monitoring Underway to Improve Performance:

30 day readmission is 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%

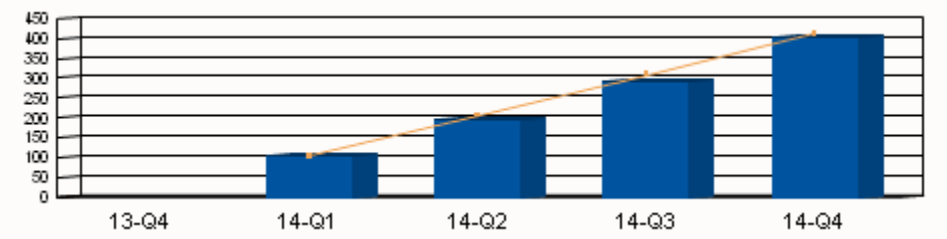
Kingston General Hospital

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-Q4		
14-Q1	104	**103**
14-Q2	194	**206**
14-Q3	292	**309**
14-Q4	401	**411**

Interpretation - Patient And Business:

At the end of Q4 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 (Q4) there are no revenue rates set for the clinical activity in question. A lead group has been established and in Q4 undertook 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

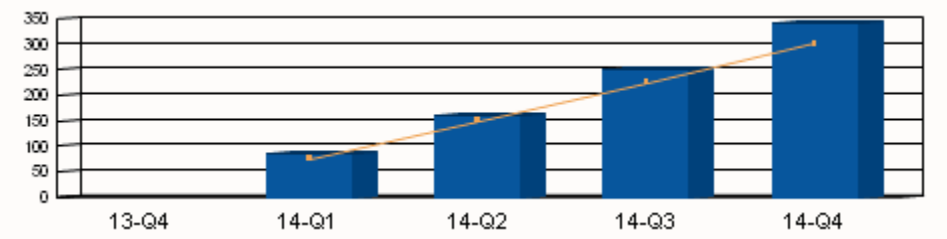
Kingston General Hospital

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-Q4		
14-Q1	87	**75**
14-Q2	159	**150**
14-Q3	251	**225**
14-Q4	340	**301**

Interpretation - Patient And Business:

At the end of Q4 admissions of patients who have a CHF is 13% away from expected volumes. The results show projected volume-based implementation of the QBP for CHF, 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 (Q4) there are no revenue rates set for the clinical activity in question. A lead group has been established and in Q4 undertook 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

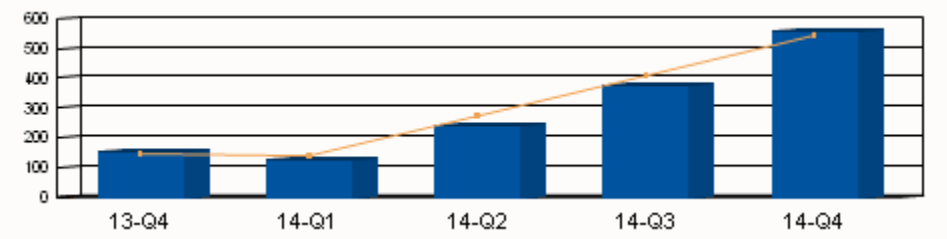
Kingston General Hospital

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-Q4	154	**145**
14-Q1	124	**136**
14-Q2	240	**272**
14-Q3	375	**407**
14-Q4	557	**543**

Interpretation - Patient And Business:

For Q4 there were 35 primary hip and 143 primary knee surgeries completed. This quarter's activity brought the YTD funded volumes for hips (205) over by 10 cases and the knee funded volumes (338) over by 4 cases. Total hip/knee revision funded volumes were also overachieved by 6 cases due to complex patient needs.

Actions & Monitoring Underway to Improve Performance:

SPA leadership and the QBP Ortho working group have worked collaboratively in ensuring that volumes were monitored/OR time allocation occurred to achieve targets. KGH Leadership discussions have occurred with the SELHIN regarding the creation of a "case number" corridor to assist in the challenges that exist in data reporting and reconciliation in meeting QBP targets for the last fiscal quarter.

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

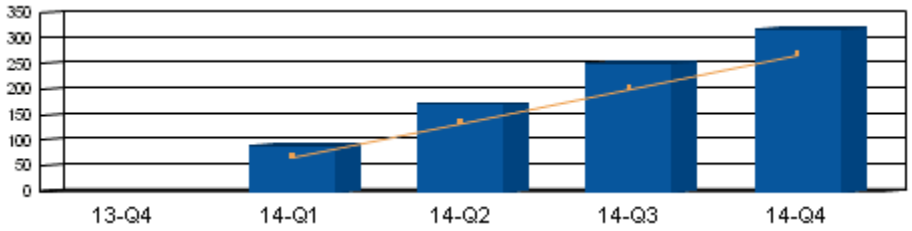
Kingston General Hospital

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-Q4		
14-Q1	88	**67**
14-Q2	170	**134**
14-Q3	249	**201**
14-Q4	318	**268**

Interpretation - Patient And Business:

At the end of Q4 admissions of patients who have had a stroke is higher than expected. The results show projected volume-based implementation of the QBP for stroke, 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 (Q4) there are no revenue rates set for the clinical activity in question. Baseline comparator reports have been issued in Q1F15 presenting information useful to the Program leads. There are no significant surprises in this report. A lead group has been established and is actively working on improvement cycles to enhance the quality of service provided. The main concern noted is the volume of patients admitted in the year compared to the number which was projected. The projection needs to be revised up for the F15 year.

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

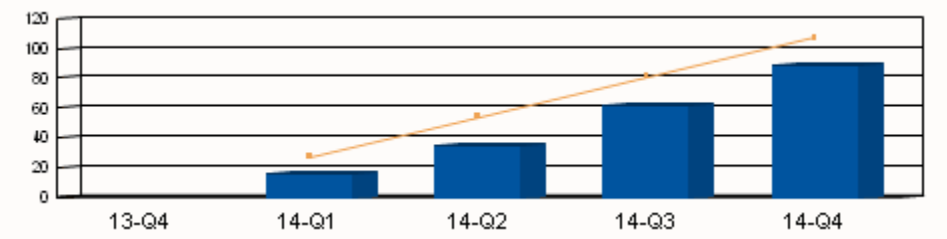
Kingston General Hospital

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-Q4		
14-Q1	16	**27**
14-Q2	34	**54**
14-Q3	61	**81**
14-Q4	89	**107**

Interpretation - Patient And Business:

For Q4 there were 15 Acute inpatient Non-Cardiac Vascular Aortic Aneurysm (AA) surgical cases completed. Raising our final YTD volumes to 53 cases which is 8 short of the year funded target of 61 cases.

For the second acute inpatient Non-Cardiac Vascular Lower Extremity Occlusive Disease (LEOD) QBP there were 13 completed cases in this quarter. The final YTD completed volumes for this surgical procedure is 36 cases which is 10 cases short of the funded targeted volumes of 46 cases.

Actions & Monitoring Underway to Improve Performance:

These Quality Based Procedures were introduced later in the fiscal year which influenced achieving the targeted volumes challenging. It had also been identified late in the implementation that "counted cases" were those that only supported scheduled activity and not non-scheduled activity which accounted for the majority of procedures being done by the vascular service.

As the Ministry information about these QBP's became clearer regarding coding etc. is was easier to develop a better method of monitoring and scheduling which will contribute to KGH being successful in meeting these targets in the new fiscal year.

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

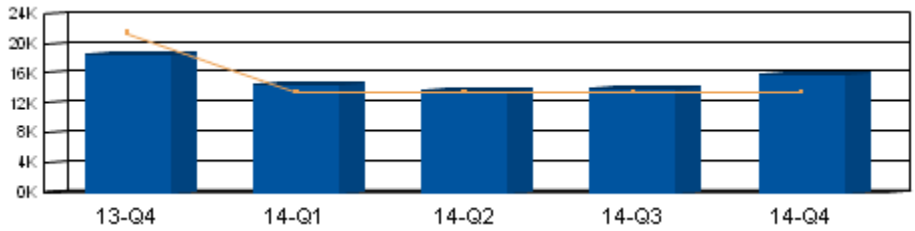
Kingston General Hospital

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-Q4	18,613	**21323**
14-Q1	14,551	**13386**
14-Q2	13,787	**13386**
14-Q3	13,867	**13386**
14-Q4	15,927	**13386**

Interpretation - Patient And Business:

For Q4 this indicator continues to meet the green target corridor. For this quarter there were 843 new patient visits, 1159 outpatient lab visits, 113 patient telephone consults and 2,494 follow ups for patients.

Actions & Monitoring Underway to Improve Performance:

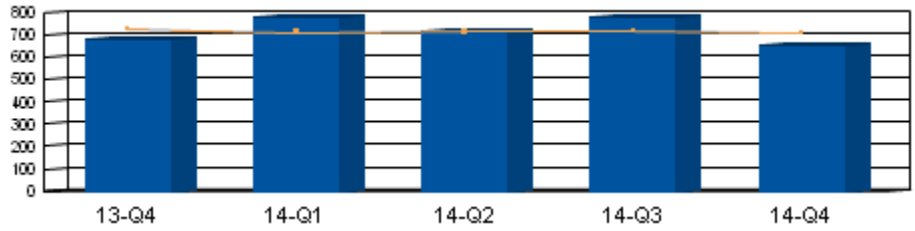
Armstong Clinic redesign is current underway that will support the transfer of the renal clinics to the Burr outpatient area in the new fiscal year.

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-Q4	678	**725**
14-Q1	776	**712**
14-Q2	717	**713**
14-Q3	780	**718**
14-Q4	653	**707**

Interpretation - Patient And Business:

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

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

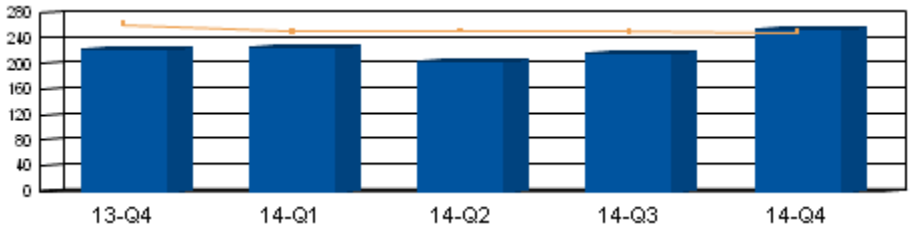
Kingston General Hospital

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-Q4	222	**262**
14-Q1	227	**250**
14-Q2	204	**251**
14-Q3	217	**250**
14-Q4	254	**249**

Interpretation - Patient And Business:

Cardiac Angioplasty volumes are slightly above target in Q4.Procedures are being done well within the recommended wait times for all urgency categories 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:

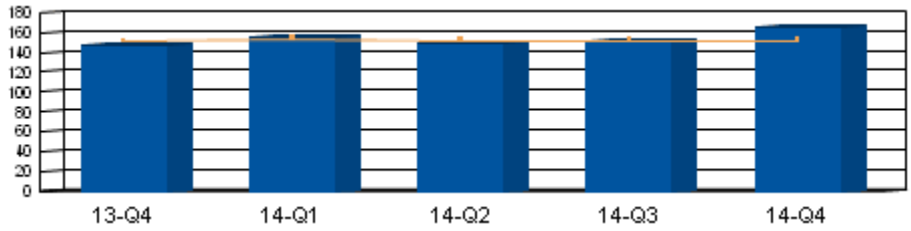
While angiography volumes remain constant, angioplasty volumes vary depending on the results of the angiogram, whether treatment is required and treatment options available. Historically, approximately 30% of angiographies lead to angioplasty which is in line with the provincial average. Q4 rate is 39% while year to date is 31%.

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

Indicator: Cardiac - Bypass Volumes



	Actual	Target
13-Q4	148	**151**
14-Q1	155	**154**
14-Q2	149	**152**
14-Q3	151	**152**
14-Q4	166	**152**

Interpretation - Patient And Business:

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

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

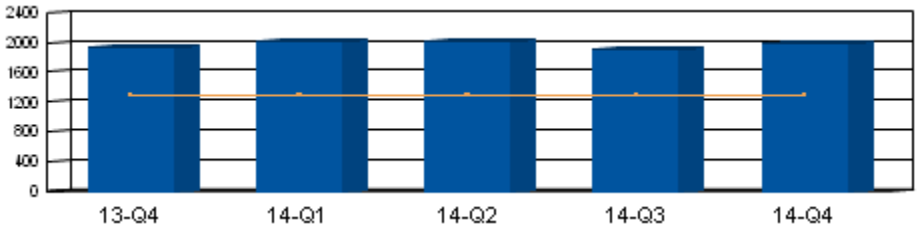
Kingston General Hospital

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: CT Hours (Wait Time Strategy Allocation)



	Actual	Target
13-Q4	1,945	**1286**
14-Q1	2,005	**1287**
14-Q2	2,005	**1287**
14-Q3	1,912	**1287**
14-Q4	1,993	**1287**

Interpretation - Patient And Business:

Higher than target hours are required to meet the needs of the KGH patient population.

Actions & Monitoring Underway to Improve Performance:

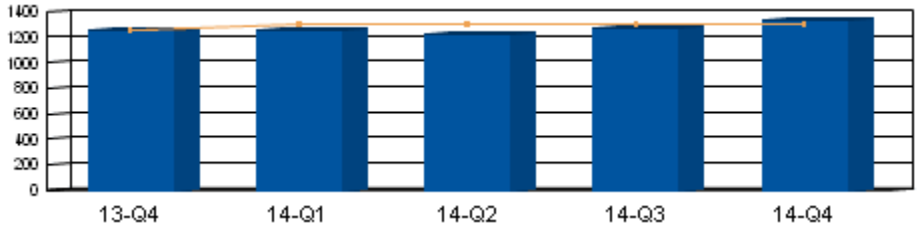
If the CT department did not operate the number of hours that they do every month we would not be able to meet the needs of the Emergency Department, the inpatient population and the Cancer Center.

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

Indicator: MRI Hours (Wait Time Strategy Allocation)



	Actual	Target
13-Q4	1,257	**1250**
14-Q1	1,254	**1300**
14-Q2	1,221	**1300**
14-Q3	1,272	**1300**
14-Q4	1,338	**1300**

Interpretation - Patient And Business:

KGH must achieve its wait time operational hours in order to qualify for wait time funding. More importantly, the MRI must operate the maximum number of hours possible so as many patients' procedures can be completed as possible. This has a direct impact on the waittimes. It is also directly impacts the patients satisfaction and the physician's ability to manage their care in a positive manner.

Actions & Monitoring Underway to Improve Performance:

Supportive of the department to manage staffing and operational hours to maximize the number of operational hours every month.

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

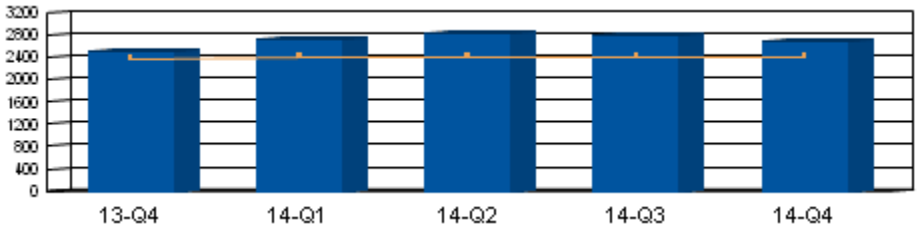
Kingston General Hospital

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 Admitted Patient Volumes – All Levels of Acuity



	Actual	Target
13-Q4	2,520	**2370**
14-Q1	2,736	**2416**
14-Q2	2,828	**2416**
14-Q3	2,804	**2416**
14-Q4	2,675	**2416**

Interpretation - Patient And Business:

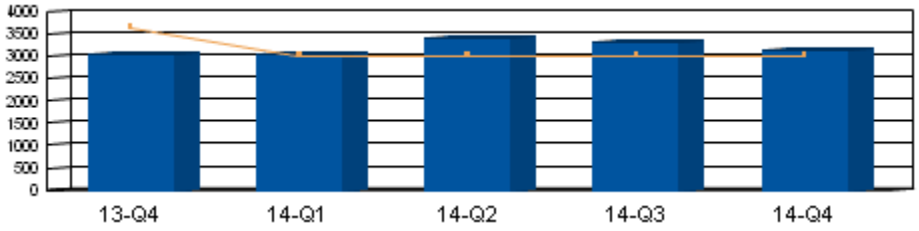
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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

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

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



	Actual	Target
13-Q4	3,028	**3647**
14-Q1	3,054	**3011**
14-Q2	3,411	**3011**
14-Q3	3,300	**3011**
14-Q4	3,139	**3011**

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: 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

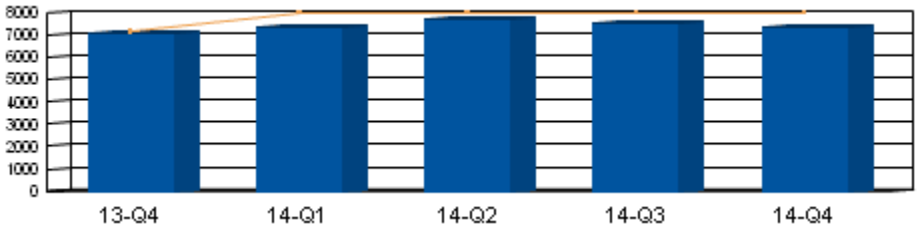
Kingston General Hospital

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 Patient Visits – High Acuity



	Actual	Target
13-Q4	7,045	**7149**
14-Q1	7,345	**7994**
14-Q2	7,755	**7994**
14-Q3	7,503	**7994**
14-Q4	7,394	**7994**

Interpretation - Patient And Business:

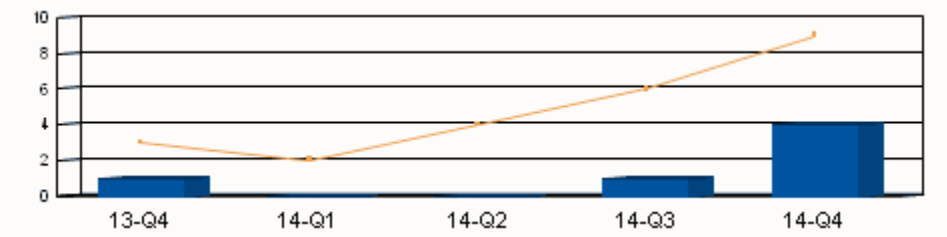
This indicator has been shaded "green" for the past 5 quarters and requires no progress comment.

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

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

Indicator: Kidney Transplants



	Actual	Target
13-Q4	1	**3**
14-Q1	0	**2**
14-Q2	0	**4**
14-Q3	1	**6**
14-Q4	4	**9**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

We continue to be 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

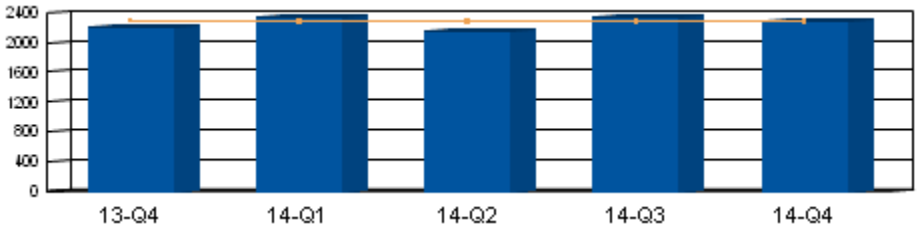
Kingston General Hospital

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 Cases (Inpatient and Outpatient)



	Actual	Target
13-Q4	2,208	**2286**
14-Q1	2,331	**2282**
14-Q2	2,150	**2282**
14-Q3	2,328	**2282**
14-Q4	2,294	**2282**

Interpretation - Patient And Business:

For Q4 this indicator continues to be in the green range. YTD there were 9,103 surgical cases completed which exceeds 111 cases from the previous year. Of these total cases 35% (3,181) were emergent/urgent (unscheduled) cases with the remaining supporting scheduled patient care.

Actions & Monitoring Underway to Improve Performance:

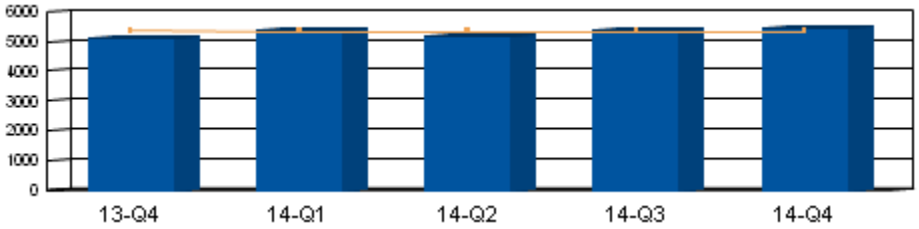
SPA leadership and the Program council monitor the OR utilization and resources to support patient care needs.

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

Indicator: OR Hours (Inpatient & Outpatient)



	Actual	Target
13-Q4	5,114	**5345**
14-Q1	5,395	**5332**
14-Q2	5,173	**5332**
14-Q3	5,412	**5332**
14-Q4	5,477	**5332**

Interpretation - Patient And Business:

For Q4 the indicator continues to be green. YTD there were 21,469 operating room hours which exceeds last year's of 20,683 hours by 786 hours. For this fiscal year 30% (6,453 hrs) were aligned with emergency cases.

Actions & Monitoring Underway to Improve Performance:

SPA Leadership and program council continue to monitor OR utilization and resources.

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

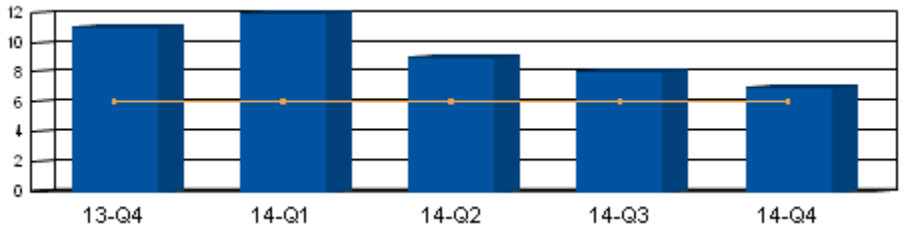
Kingston General Hospital

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: Stem Cell Transplants



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

Interpretation - Patient And Business:

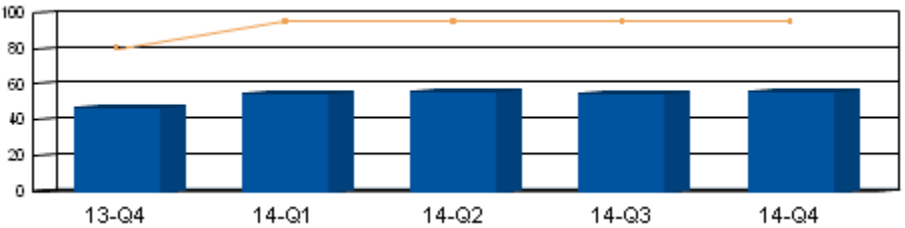
This indicator has been shaded "green" for the past 6 quarters and requires no progress comment.

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

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



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

Interpretation - Patient And Business:

Q4 results of 56% represents a slight improvement 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%

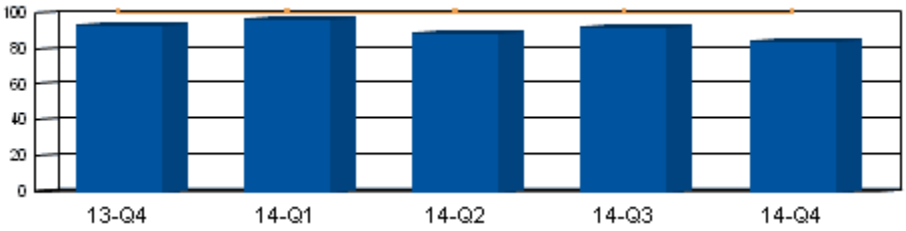
Kingston General Hospital

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: Percent of Contracted Volumes Achieved



	Actual	Target
13-Q4	93	**100**
14-Q1	96	**100**
14-Q2	88	**100**
14-Q3	92	**100**
14-Q4	84	**100**

Interpretation - Patient And Business:

As of Q4, 4 of 25 (84%) contracted volume indicators had Red status. They are primary hip and knee surgery (target exceeded by 10 cases), Adult General Surgery - anorectal, Peds scoliosis and Peds 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?**
One hundred (100) percent of Individual Team's Engagement Plan have been completed. Ninety-seven (97) percent of leaders have been trained on building engagement and toolkits available. The recognition program was tweaked last year, with a corporate decision not to made substantial changes to the program until Fiscal 2015.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
Two "*Take Action Guide (TAG)*" workshops were conducted in January and March with twenty-seven (27) leaders attending. Eighty-nine leaders have attended with four missing the training. Two were individuals who are in the process of being removed from the Leadership Group listing and two were executives. The hospital commenced communication of engagement successes and two more stories are awaiting publication through the KGH This Week publication. Volunteer engagement survey results (conducted by PAVR-O) were received with improvement noted in most categories.

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?**
There is a KGH 2014-5 Improvement Priority: *Address priorities identified in our employee and physician engagement surveys.* Target: *Quarterly engagement plan deliverables are met.* This plan focusses on the four areas that the NRCC survey indicated would be the most effective in moving the engagement scores. They are Trust, Education and Career Development, Wellness; and Recognition. There are tactics to ensure follow-up on the plans and further enhance leadership development. The plan also includes action for the volunteer and physician engagement surveys.

Kingston General Hospital

MS #07

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

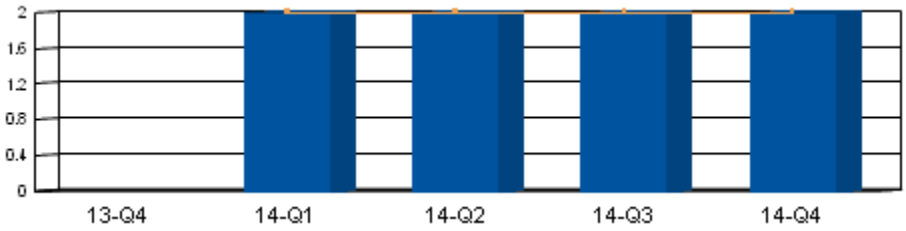
Kingston General Hospital

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

Interpretation - Patient And Business:

Leadership and Learning had a booth at Inter-professional Expo to highlight correlation between Engagement and Wellness. Communication to staff in publications of engagement success stories. Leaders completed action plans and will submit as part of performance agreement. Effective Team Leadership training workshops continued with 13 leaders attending in Q4.

Actions & Monitoring Underway to Improve Performance:

Corporate tactical plans being finalized for next fiscal year for Recognition, Trust, Health & Wellness and Learning & Development. Highlights will include psychologically safe work environment and leadership development.

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

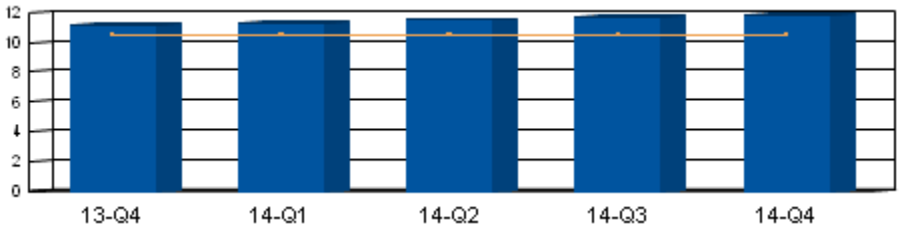
Kingston General Hospital

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-Q4	11.1	**10.5**
14-Q1	11.3	**10.5**
14-Q2	11.5	**10.5**
14-Q3	11.7	**10.5**
14-Q4	11.9	**10.5**

Interpretation - Patient And Business:

Success of the measures taken and the areas of focus have produced gains in reducing the number of employees in the attendance program, reducing the number of incidents or frequency of absence by more than 80%, increasing the number of employees with perfect attendance, and reducing the length of absence through disability management. This year saw an increase that spiked once new collective agreement language came into effect last fall. The exclusion of certain types of illness and disability from the attendance program has spawned a review of our program and plan ahead.

Actions & Monitoring Underway to Improve Performance:

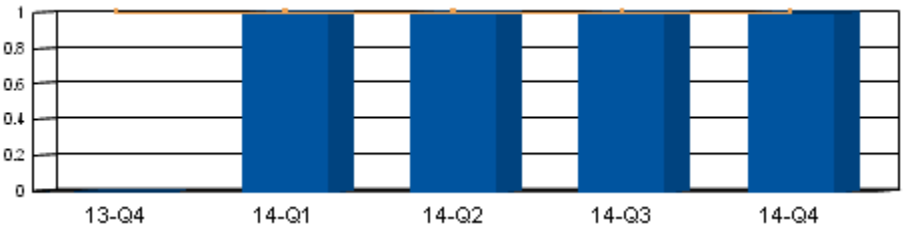
Proposal to manage CUPE sick time language impact, short term absences and chronic disability exclusions will go to Operations Committee for approval. Includes short term resources, data management and technology.

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

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



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

Interpretation - Patient And Business:

Two Take Action Guide (TAG) workshops were conducted (January and March) with 27 leaders attending. 89 leaders have now attended TAG workshops in this year. 4 leaders were not able to attend.
90 Engagement Plans have been completed (100%).

Actions & Monitoring Underway to Improve Performance:

Engagement process and continuation embedded into 2014-15 Performance Agreements for all Leaders. Performance Reviews and conversations now part of F15-16 Corporate Plan. Finalization of corporate tactics to respond to Engagement Survey underway.

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

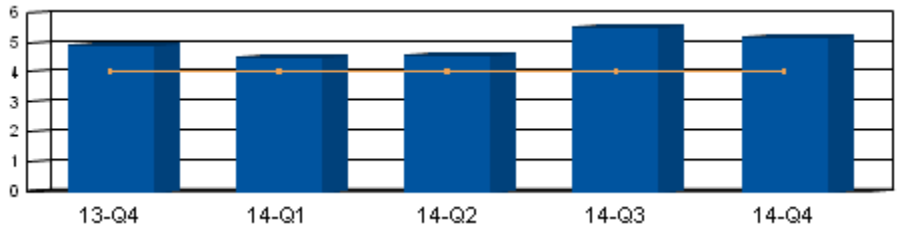
Kingston General Hospital

MS #07

People

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

Indicator: Percent Sick Time Hours



	Actual	Target
13-Q4	4.9	**4**
14-Q1	4.5	**4**
14-Q2	4.6	**4**
14-Q3	5.5	**4**
14-Q4	5.2	**4**

Interpretation - Patient And Business:

This year saw an increase that spiked once new collective agreement language came into effect last fall. Focus groups on wellness and absenteeism were conducted, and a review of external programs.

Actions & Monitoring Underway to Improve Performance:

Proposal to manage new sick time language impact, short term absences and chronic disability exclusions will go to Operations Committee for approval. Includes short term resources, data management and technology.

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

Green

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

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

1. **What is our actual performance on the indicator for this milestone as listed above?**
Seventeen (17) of the twenty (20) indicators of the Occupational Health and Safety Scorecard were met, which ends the year in a green status. Red items were Incident Investigations, Respiratory Fit Testing; and 21 day management response to Joint Health and Safety Committee monthly inspections and recommendations. Additionally, we had a forty percent (40%) decrease in needle-stick injuries in Q4 and only four (4) musculoskeletal injuries that results in lost time from work for the year, which is significantly below the target of ten (10) or less. Subsequently, we have achieved green status for Q4.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?**
Safe Reporting roll-out in January with configuration to facilitate improved data collection. Twenty-five (25) of ergonomic assessments were completed. Re-trending of some stairwells and the floor in the Dishroom in the Kitchen has been replaced. Behavioural Crises (BCA) prompts have now been incorporated into the Security post Code White Process. The patient BCA record has been revised to provide improved clarification of the activation criteria and incorporates “Risk of Self Harm” as a new criteria for activation.

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?**
There is a KGH 2014-5 Improvement Priority: *Reduce the incidence of musculoskeletal injuries and needle-stick injuries through the implementation of hazard recognition and control.* Target: *Musculoskeletal (MSI) injury claims are reduced from 30 to less than or equal to 24 per year.* Target: *Needle-stick injuries are reduced from 54 to less than or equal to 48 per year .* Tactics planned are: Needle Safety Training roll-out; assessment of use of insulin pens, management form redesigned to encourage improved analysis of “why” the needle-stick injury happened and “what can be done” to prevent in the future; staff in-services on new transfer boards; ergonomist support to managers in conducting incident investigations on MSI related injuries that have resulted in lost time or healthcare claims.

Kingston General Hospital

MS #08

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

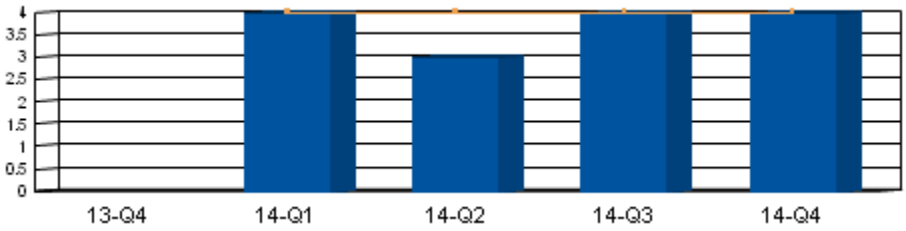
Kingston General Hospital

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

Interpretation - Patient And Business:

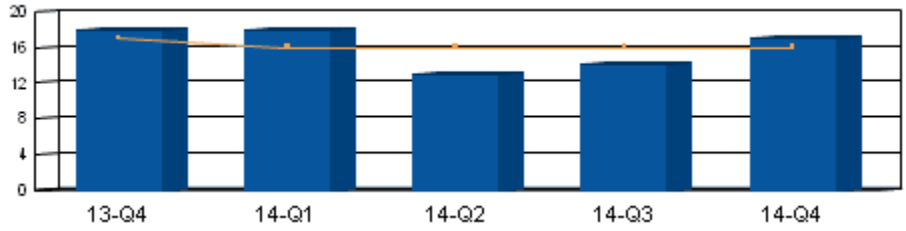
4 H&S tactics focused on top sources of harm to staff (violence, musculoskeletal injury, falls, and needlesticks) have all made progress this quarter with Needle Safety and Safe Patient Handling Training complete and to be launched in May. Significant progress Q4 on improvements to the Behavioural Crisis Alert (BCA) program which will be launched in Q1.

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

Interpretation - Patient And Business:

3 indicators in red including: Incident Investigation Completion, Respirator Fit Testing Compliance, and 21 Day Management Response to JHSC recommendations.

Actions & Monitoring Underway to Improve Performance:

Incident Investigation- effective April 1/14, Safety Advisor and Ergonomist to support the investigation of incidents that result in WSIB healthcare and lost time injury claims. Respirator Fit Testing- continued efforts to organize targeted blitzes to update staff fit testing in areas of low compliance. 21 Day Management Response- Effective April/14, notices to be sent in advance of the 21 day due date to managers who have not yet provided a written response to the JHSC inspection report.

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? (Name the tactic and describe the status)

Q4 Status

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

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?

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

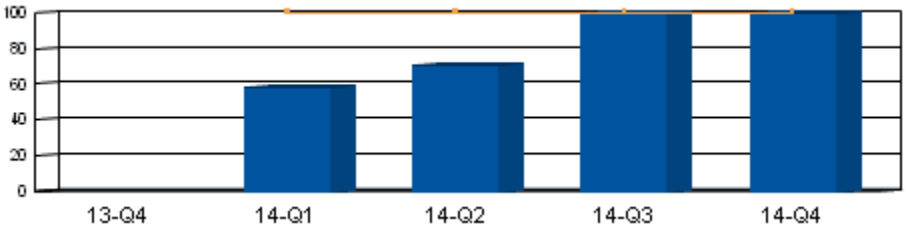
Kingston General Hospital

MS #09

Processes

Adoption of continuous improvement principles is increased

Indicator: Number of Improvement Priorities Using PDSA Improvement Cycles



	Actual	Target
13-Q4		
14-Q1	58	**100**
14-Q2	71	**100**
14-Q3	100	**100**
14-Q4	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 the stage 2 approval status was not achieved in fiscal 2014. The determination by the Ministry of Health and Long Term Care, Capital Branch (Ministry) that a combined Kingston General Hospital (KGH) and Hotel Dieu Hospital (HDH) Surgical Plan (SP) would be required before the Stage 1 submission was considered to be complete interrupted the planned time line. This requirement has delayed consideration of Stage 2 approval for the project. It had been hoped in Quarter 3 that once Agnew Peckham was retained that expedited discussions could result in the SP report's completion, submission, and decision before fiscal 2014 years end, but it became apparent in Q4 that this was not achievable. HDH and KGH needed to work through the process of developing the assumptions and plans. It is now expect that the SP will be completed in Q1 Fiscal 2015 for submission to the Ministry.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** The draft SP report prepared by Agnew Peckham has received approval by management of both KGH and HDH in April 2014. Also in April, Agnew Peckham's principle, Lucy Brun reviewed our approach and assumptions with the Ministry team to ensure assumptions and approach were aligned with Ministry expectations. A similar meeting with the Southeast Local Health Integration Network (SELHIN) is planned for May. These preparatory meetings are to ensure the SELHIN and Ministry are comfortable with our approach and assumptions to avoid any structural problems in the draft report. The actual submission we expect to make in June 2014.

3. **Are we on track to meet the milestone by year end?** It is our new goal to achieve approval for Stage 2 in Fiscal 2015. The most recent challenge is the Provincial Election. Elections in the past have been known to interrupt many of the Ministry's decision making processes so there is a risk of some delays, but given this election is early in the fiscal year we expect approval to be possible within the fiscal calendar.

4. **What new tactics are planned to ensure this milestone is met?** As soon as the submission is made we will maintain contact with the Ministry to encourage processing of the submission. Senior Leadership will also begin regular follow up with our contacts at the Ministry. While this is underway we will begin to prepare for Stage 2 work, the next milestone. Internal way finding project is also progressing on plan as is our efforts on improving our culture of philanthropy.

Kingston General Hospital

MS #10

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

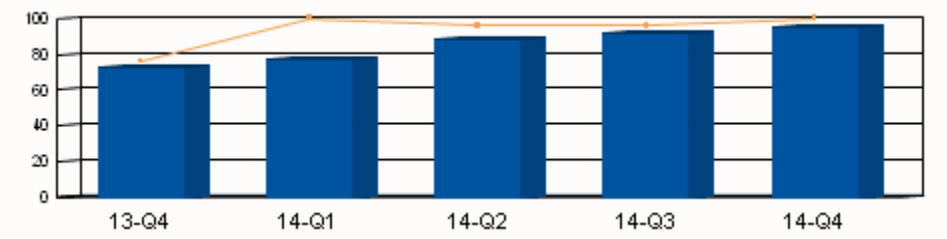
Kingston General Hospital

MS #10

Facilities

Phase 2 redevelopment is advanced

Indicator: Quarterly Carpet Removal Targets are Met



	Actual	Target
13-Q4	73.0	**76**
14-Q1	76.8	**100**
14-Q2	88.6	**96**
14-Q3	92.0	**96**
14-Q4	95.3	**100**

Interpretation - Patient And Business:

FAPC 5 and Davies 5 were completed in Q4. Project will be complete (less deficiencies) in Q1 once we finish Dietary 2 (Same day Surgery), Sleep Lab (Kidd 6), Victory 2 corridor (change order)

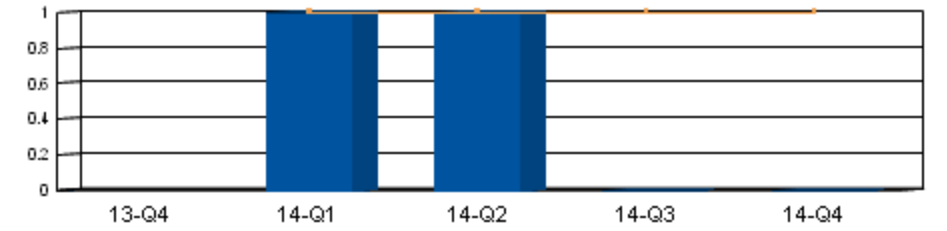
Definition: DATA: Allan McLuskie COMMENTS: Allan McLuskie SUPPORTING INDICATOR

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)

Phase 2 redevelopment functional programming commences

Indicator: Stage 2 Approval Status



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

Interpretation - Patient And Business:

KGH and HDH are in process of completing a Surgical Plan with Agnew Peckham to support Phase 2 redevelopment that will recommend the total number of OR's that each hospital would construct to support future services. It is expected that the report will be submitted to the Capital Branch of the Ministry of Health and Long Term Care in June. If accepted by the Capital Branch, the next step in the process for Phase 2 would be Functional Planning.

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 ((1)staff scheduling system, (3) automated drug cabinet (ADC) project, (2) lab order entry project, (4) phase 3 Emergency Department Information System, (4) 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, however we have listed indicator as yellow due to the unknowns at the end of March 31, 2014 in respect to time lines for some of the projects. (see below)

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** (1) Staff Scheduling's implementation phase planning began in January as the design phase details were finalized. Due to increased scope and complexities the project duration and cost the project has undergone additional review in Q4. Implementation kick off is now expected May 26, 2014. (2/3) Recruitment within the Project Management Office allowed us to make positive progress on the Lab Order Entry and Automated Drug Cabinet projects since last quarter. (2) A Laboratory Steering Committee meeting was held on April 4, 2014 to confirm proposed schedule for the project. (3) The ADC Steering Committee reconvened on April 7th to confirm project scope for the final phase of the project. Both projects are back on track with the recruitment of Project Management Staff. (4) The EDIS Steering Committee approved the Project Charter for phase 3 in February 2014. The project is in the executing phase and is on track to go live in the fall of 2014. (5) Regional Plan for HIS scope and process owners have been identified for the RFP requirements sessions. Communications are finalized and a kick-off meeting is scheduled for May 6 (RFP requirements gathering will be lead by HealthTech).

3. **Are we on track to meet the milestone by year end?** EDIS, Lab Order Entry and Automated Drug Cabinets are expected to be back on schedule for completion in 2014/15, but we were behind schedule as at March 31, 2014. Staff scheduling is a multi-year project that is still projected to complete in Fiscal 2015/16 and the Steering Committee will re-examine progress through implementation in the next few quarters to determine if the overall schedule has been impacted by the analysis required over the last few months. The Regional RFP is progressing well, and is subject to the oversight of all regional partners and while it is behind our original schedule we are comfortable with the position at March 31, 2014. We are hopeful it will be completed in Fiscal 2015 and will keep the Board apprised of progress.

4. **What new tactics are planned to ensure this milestone is met?** All tactics and plans are being overseen by the respective steering committees and are advancing as planned. No new tactics to report at this time.

Kingston General Hospital

MS #11

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

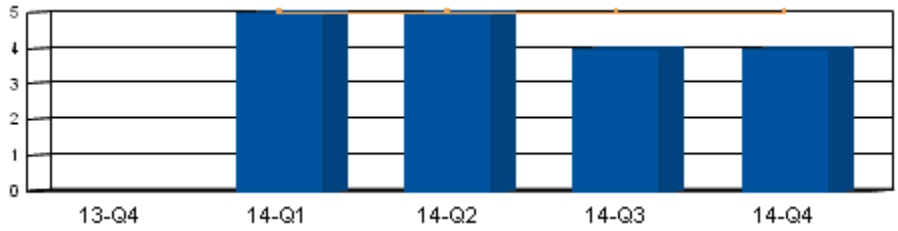
Kingston General Hospital

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

Interpretation - Patient And Business:

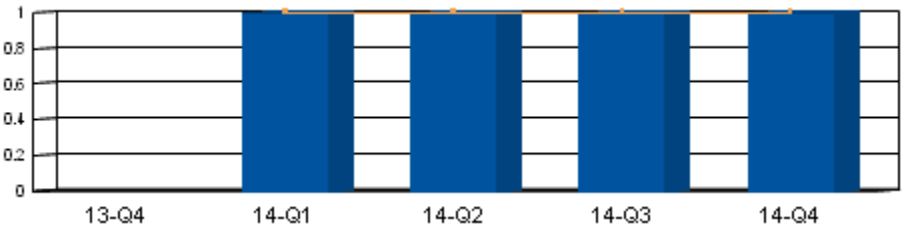
Progress continues to be made on all five projects. Recruitment within the Project Management Office allowed us to make positive progress on the Lab Order Entry and Automated Drug Cabinet
projects since last quarter. Cost and schedule estimates are the focus for the Staff Scheduling project.

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-Q4		
14-Q1	1	**1**
14-Q2	1	**1**
14-Q3	1	**1**
14-Q4	1	**1**

Interpretation - Patient And Business:

Implementation phase planning began in January as the design phase details were finalized. An initial draft implementation plan has been created. Due to increased scope and complexities the project duration and cost is greater than the original business case which will require review to ensure appropriate ROI. Implementation kick off is expected May 26, 2014.

Actions & Monitoring Underway to Improve Performance:

Steering committee scheduled to approve an implementation timeline that includes a build phase, a testing phase and a deployment phase.

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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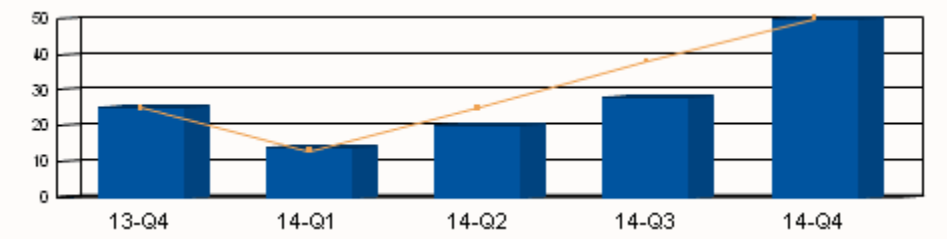
Kingston General Hospital

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-Q4	25	**25**
14-Q1	14	**13**
14-Q2	20	**25**
14-Q3	28	**38**
14-Q4	50	**50**

Interpretation - Patient And Business:

A Steering Committee meeting has been scheduled for April 4, 2014 to confirm proposed schedule for the project. Targeting March 31 to begin an 8-week implementation process with NICU and PACU.

Actions & Monitoring Underway to Improve Performance:

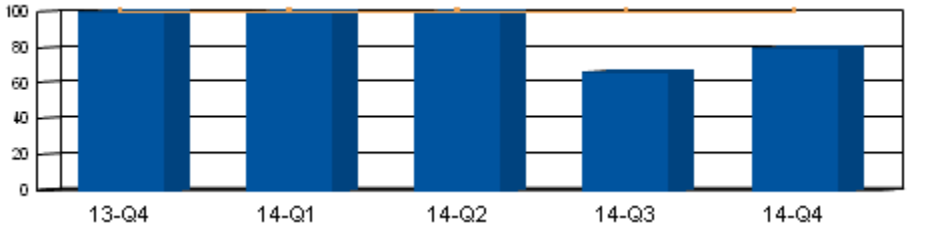
Implementation timeline confirmed by Steering to complete installs by end of Q3 F'15.

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-Q4	100	**100**
14-Q1	100	**100**
14-Q2	100	**100**
14-Q3	66	**100**
14-Q4	80	**100**

Interpretation - Patient And Business:

The Steering Committee will be reconvening on April 7th to confirm project scope for the final phase of the project.

Actions & Monitoring Underway to Improve Performance:

While the project did not meet the original target, workflow changes were implemented to support the final phase of the project. The next steps are to confirm resources and project schedule based on approved scope.

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

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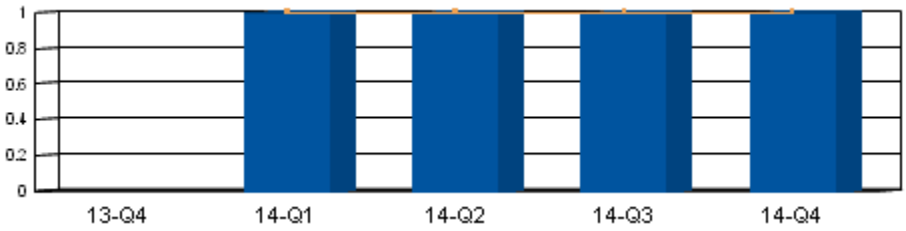
Kingston General Hospital

MS #11

Technology

Strategic technology projects are completed on time and on budget

Indicator: Phase 3 of EDIS is Implemented



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

Interpretation - Patient And Business:

The EDIS Steering Committee approved the Project Charter for phase 3 in February 2014. The work on the inbound QCPR interface began on March 3, 2014. The project is in the executing phase and is on track to go live in the fall of 2014.

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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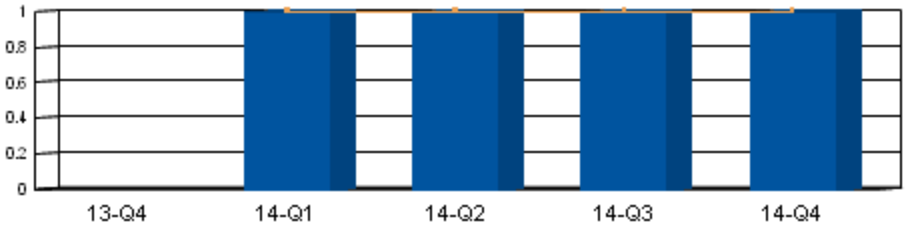
Indicator: Participation in a Regional Plan for IT Systems



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

Interpretation - Patient And Business:

Scope and process owners have been identified for the RFP requirements sessions. Communications are finalized and a kick-off meeting is scheduled for May 6 (RFP requirements gathering will be lead by HealthTech).

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?** Hospital Operations ended the year with a $500,000 negative variance from plan and the corporate overall result were $27 million positive; a very positive result.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** No new tactics were implemented Quarter 4, the results were due to actions taken through out the year and prior years. As reported by our CFO throughout the year we had several areas of operating pressures, but fortunately these were offset by continuing positive variances in other portfolios. These results continued in Q4, for a net operating impact of $500,000 loss on operations. The significant positive results corporately were due to: provincial support of working capital that we were successful negotiating ($7 million), earning of PCOP revenue in each of fiscal 2012 and 2013 that was finally settled prior to year end ($9.4 million), and of course accounting for capital purchases not yet completed. Please see the Financial Reports for more detail (Year End Audited Statements and the MDA).

3. **Are we on track to meet the milestone by year end?**
   As noted above we have met this milestone for Fiscal 2014.

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

Kingston General Hospital

MS #12

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

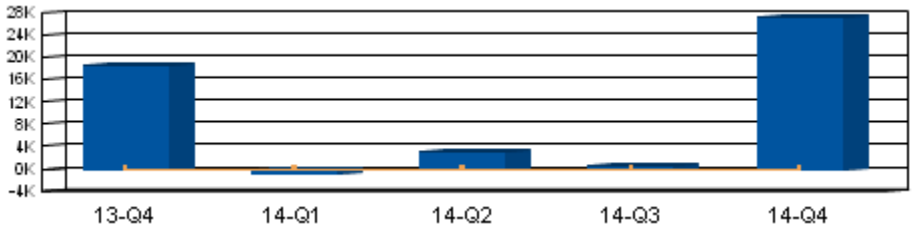
Kingston General Hospital

MS #12

Finances

Financial health is sustained

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



	Actual	Target
13-Q4	18,555	**0**
14-Q1	-748	**0**
14-Q2	3,019	**0**
14-Q3	526	**0**
14-Q4	27,373	**0**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

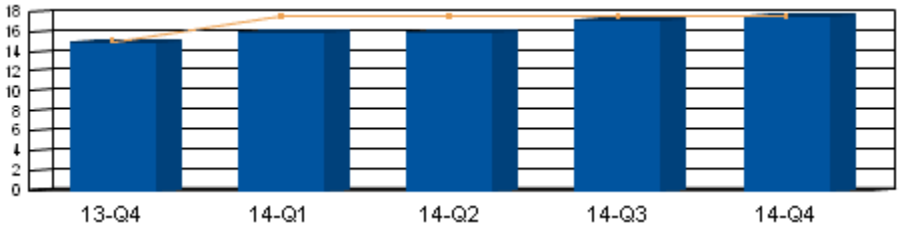
The hospital ended fiscal 2014 with a total surplus of $26.7 million. Regular hospital operating results were balanced. Non-operational items contributing to the surplus for fiscal 2014 included $ 7 million working capital deficit funding relief and $9.4 million prior years' POCP funding. Operating funding provisioned for capital expenditure provides the remainder of the surplus.

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-Q4	15.0	**15.0**
14-Q1	16.0	**17.5**
14-Q2	15.9	**17.5**
14-Q3	17.1	**17.5**
14-Q4	17.5	**17.5**

Interpretation - Patient And Business:

The total dollars available for capital investment will support the replacement of clinical and non-clinical equipment, building infrastructure renewal and information management technology.

Actions & Monitoring Underway to Improve Performance:

The hospital achieved the 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.

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

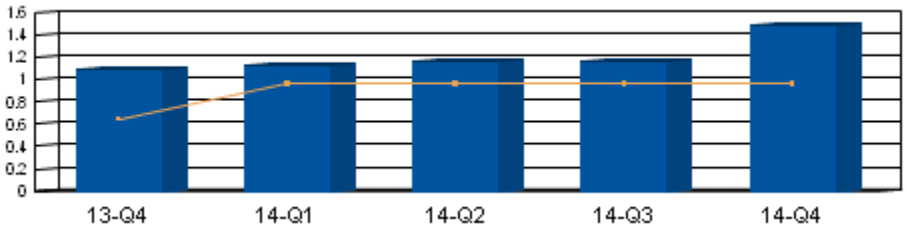
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Current Ratio



	Actual	Target
13-Q4	1.10	**0.64**
14-Q1	1.12	**0.96**
14-Q2	1.16	**0.96**
14-Q3	1.17	**0.96**
14-Q4	1.48	**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 current ratio at year end represents an improvement over the prior year of position of 1.15:1. This reflects receipt of one-time Ministry funding which was applied to reduce the short term cash advance owing to the SELHIN.

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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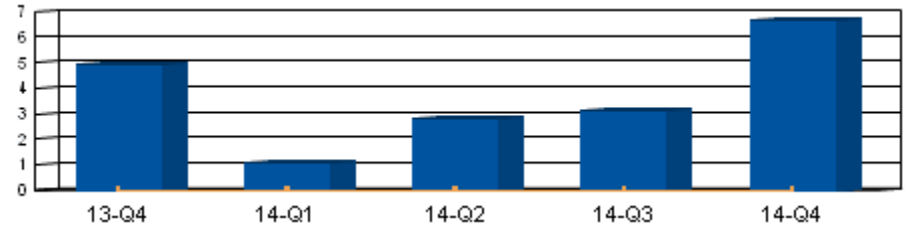
Indicator: Total Margin



	Actual	Target
13-Q4	4.97	**0**
14-Q1	1.08	**0**
14-Q2	2.78	**0**
14-Q3	3.09	**0**
14-Q4	6.67	**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 fiscal 2014, the total margin exceeded the Ministry acceptable range (0 - 3%). When non-operational one-time funding received from the Ministry this year is removed, the total margin would become 3.13%. Regular hospital operating results were balanced. The total surplus result includes non-recurring funding ($7.0 million working capital deficit funding relief, $9.4 million prior years' POCP funding), and operational funds provisioned for capital investment.

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

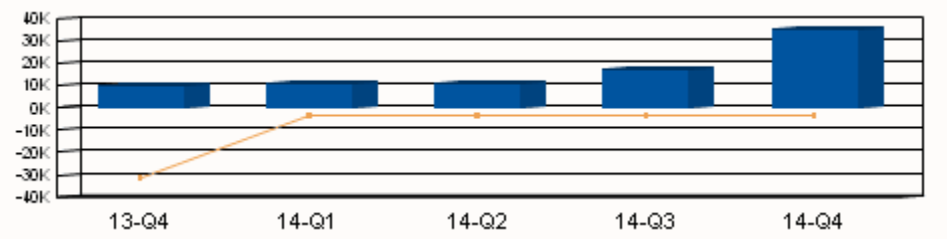
Kingston General Hospital

MS #12

Finances

Financial health is sustained

Indicator: Working Capital ($000's)



	Actual	Target
13-Q4	10,071	**-31500**
14-Q1	11,321	**-3706**
14-Q2	11,312	**-3706**
14-Q3	17,216	**-3706**
14-Q4	35,156	**-3706**

Interpretation - Patient And Business:

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

Actions & Monitoring Underway to Improve Performance:

The hospital operations working capital position at year end represents an improvement over the prior year of $14.3 million. This reflects receipt of one-time Ministry funding which was applied to reduce the short term cash advance owing to the SELHIN.

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?** In Q1 and Q2 there was development of a framework and workplan for a communications skill development workshop and roll out. Q3 and Q4 saw the unfolding of four training sessions with 90% of leaders completing the education, and providing very positive feedback on the caliber and value of the training. As a foundational step to an external engagement plan, there has been a focus on redesign of the KGH website. This has involved an RFP process which was completed in Q4 and enabled the detail planning for the work of redesign to proceed.

2. **What tactics were implemented this quarter to address the progress of the priorities to achieve the milestone?** Education of leaders continued in Q4, and application of the tools occurred at program/service level as well as at the corporate level. Communication throughout the development of the Annual Corporate Plan is illustrative of application of the communication tools and methodologies. The RFP for the website redesign was completed in Q4.

3. **Are we on track to meet the milestone by year end?** The workplan was achieved and the target was met.

4. **What new tactics are planned to ensure this milestone is met?** With leadership communication training now delivered to 90% of KGH Leaders, there is capacity to have consistency in approach with communication of initiatives and change. The Strategy Management and Communications team is exploring the logistics of capturing the remaining 10% of leaders, and newly hired leaders to ensure access to skills development and tools. As well, the team is rolling out a new service model that aligns Strategic Communication Advisors to partner with dedicated time to each program/department/service to support use of the communication training and skills in translating the strategy and improving issue, change and project communication.

Kingston General Hospital

MS #13

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

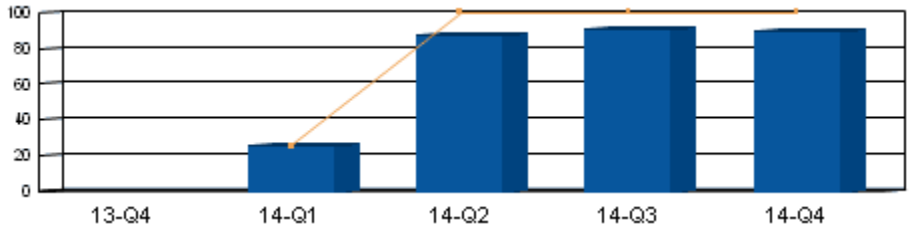
Kingston General Hospital

MS #13

Communication

KGH communication standards are consistently implemented across the organization

Indicator: Percent of Leaders Who Complete Communication Training



	Actual	Target
13-Q4		
14-Q1	25	**25**
14-Q2	87	**100**
14-Q3	91	**100**
14-Q4	90	**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. Four training sessions were held in October, November and December, 2013 as well as January 2014. As of Q4, 90 per cent of leaders have completed communications training. This is down from 91 per cent in Q3 as a result of one individual who was registered but unable to complete day 2 of the training.

Actions & Monitoring Underway to Improve Performance:

With leadership communication training delivered to 90 per cent of KGH leaders, the Strategy Management and Communication department has turned its focus to implementing a new service model that will see us partnering with leaders across the organization to leverage their new skills to support translating of strategy within programs, departments and teams as well as improving issue, change and project communication.

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%

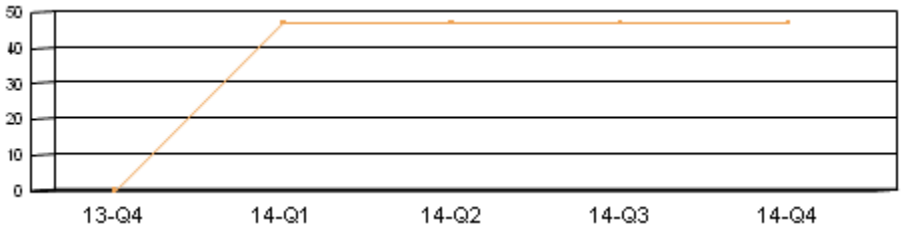
Kingston General Hospital

MS #13

Communication

KGH communication standards are consistently implemented across the organization

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



	Actual	Target
13-Q4		0
14-Q1		47
14-Q2		47
14-Q3		47
14-Q4		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 is informing 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-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	G	G	G	G	↑
	The top sources of preventable harm to patients are addressed	Number of Preventable Harm to Patient Indicators Met	N/A	Y	Y	R	R	↓
	The top sources of GRIDLOCK are addressed.	Percent of Recommendations Completed as per Incident Review Triggered by Code GRIDLOCK - (QIP)	N/A	Y	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	G	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	R	Y	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	Y	Y	G	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	G	G	G	G	↑
	The top sources of preventable harm to staff are addressed	Number of Preventable Harm to Staff Indicators are Met	N/A	G	Y	G	G	↑
Processes	Adoption of continuous improvement principles is increased	Number of Improvement Priorities Using PDSA Improvement Cycles	N/A	G	G	G	G	↑
Facilities	Phase 2 redevelopment functional programming commences	Stage 2 Approval Status	N/A	Y	Y	R	R	↓
Technology	Strategic technology projects are completed on time and on budget	Number of Strategic Technology Projects on Time and on Budget	N/A	G	G	Y	Y	↑
Finances	Financial health is sustained	Hospital Operations Actual vs Plan Variance ($000's)	G	R	G	G	G	↑
Communication	KGH communication standards are consistently implemented across the organization	Percent of Leaders Who Complete Communication Training	N/A	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

2014 QIP

			13-Q4	14-Q1	14-Q2	14-Q3	14-Q4	
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	Y	Y	R	R	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	R	R	G	G	G	↑
		Anti-biotics Dispensed Quarterly to ED and Admitted Patients per 1000 Patient Days - (QIP)	G	Y	Y	G	G	↑
		Hand Hygiene Compliance - (QIP)	Y	Y	R	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	G	
		Percent Mortality Reviews Completed with Review of Record Level HSMR Data - (QIP)	N/A	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	Y	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	G	G	G	G	↑
Increase our focus on complex-acute and specialty care	Regional Protocols for targeted patient populations are in place and reflect KGH's role	Improvement in KGH 30-Day Readmission Rate as per SE LHIN CMG Profile - (QIP)	G	R	R	Y	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

Health and Safety	Health & Safety		13-Q4	14-Q1	14-Q2	14-Q3	14-Q4
		OHS - JHSC Health & Safety Inspections Completed	G	G	G	G	G
		OHS - 21 Day Response to JHSC Identified Hazards	Y	R	R	Y	R
		OHS - Management Inspection Program	G	G	R	Y	Y
		OHS - Respirator Fit Testing & Training Compliance	Y	R	R	R	R
		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 - WSIB NEER Performance Index - 2013	N/A	N/A	N/A	N/A	G
		OHS - Incident Investigations Complete	R	Y	R	R	R
		OHS - Lost Time Severity Rate (Days Lost/100 Workers)	N/A	Y	R	R	G
		OHS - Needlestick Injuries (NSI's) Only	R	G	R	R	G
		OHS - Total MSI Incidents	Y	Y	Y	Y	Y
		OHS - MSI Lost Time Injury Claims (LTIs)	G	G	G	Y	G
		OHS - MOL Reported Critical Injury Incident	G	G	Y	G	G

120	13-Q4	14-Q1	14-Q2	14-Q3	14-Q4
OHS - WSIB Lost Time Claims	G	G	G	G	G
OHS - WSIB Health Care Claims	R	Y	Y	R	Y
OHS - Occupational Illness Reported to MOL	Y	G	G	G	G
OHS - MOL Orders Issued During Site Visit	G	G	G	G	G
OHS - Mandatory Safety Training (Overall Compliance)	Y	Y	R	R	Y
OHS - Pre-Placement Health Screening Completed	G	G	Y	G	G

Indicates improving performance to target over the past 5 quarters

Indicates worsening performance to target over the past 5 quarters

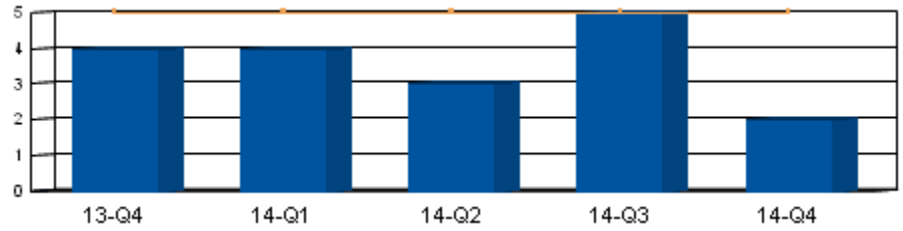
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB Lost Time Claims



	Actual	Target
13-Q4	4	**≤5**
14-Q1	4	**≤5**
14-Q2	3	**≤5**
14-Q3	5	**≤5**
14-Q4	2	**≤5**

Interpretation - Patient And Business:

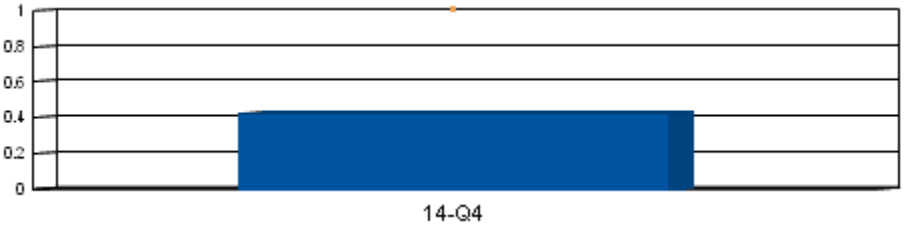
2 LTIs in Q4- one being in the ED (MSI) and the other at the FAPC doors (Fall).

Based on approval/denials of lost time claims that occurred throughout the year, the total of lost time injuries for the year was 13 (Goal was 19 or less).

Definition:

Target: Target 2013/14:

Indicator: OHS - WSIB NEER Performance Index - 2013

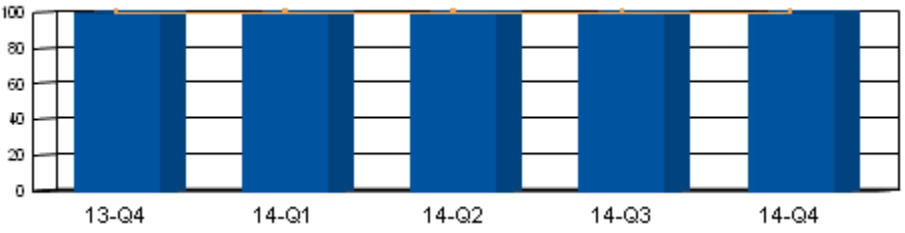


	Actual	Target
14-Q3	0.42	**≤1**

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 - JHSC Health & Safety Inspections Completed



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

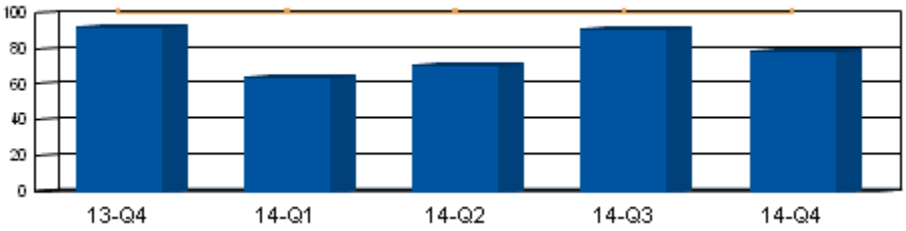
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - 21 Day Response to JHSC Identified Hazards



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

Interpretation - Patient And Business:

Jan- 78%
Feb- 75%
Mar- 82%

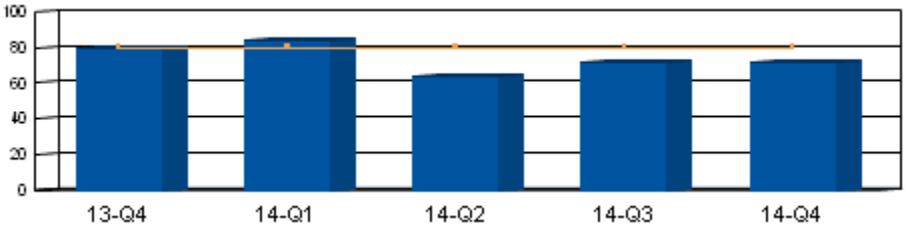
Actions & Monitoring Underway to Improve Performance:

Effective April/14- OHSW will send notice to the Manager, prior to the 21 day due date, reminding them of the required response.

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%

Indicator: OHS - Management Inspection Program



	Actual	Target
13-Q4	80	**>80**
14-Q1	84	**>80**
14-Q2	64	**>80**
14-Q3	72	**>80**
14-Q4	72	**>80**

Interpretation - Patient And Business:

Q1- 84%
Q2- 64%
Q3- 72%
Q4- 72%

Overall annual completion= 73%

Actions & Monitoring Underway to Improve Performance:

Quarterly Inspection reminders to go into calendars of leaders who are required to perform effective April 1/14.

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%

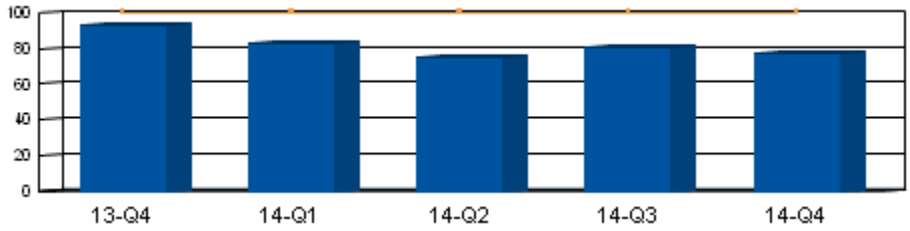
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - Respirator Fit Testing & Training Compliance



	Actual	Target
13-Q4	93	**100**
14-Q1	83	**100**
14-Q2	75	**100**
14-Q3	81	**100**
14-Q4	77	**100**

Interpretation - Patient And Business:

77% each month. Considerable testing done through a number of blitzes however additional staff expired during the quarter.

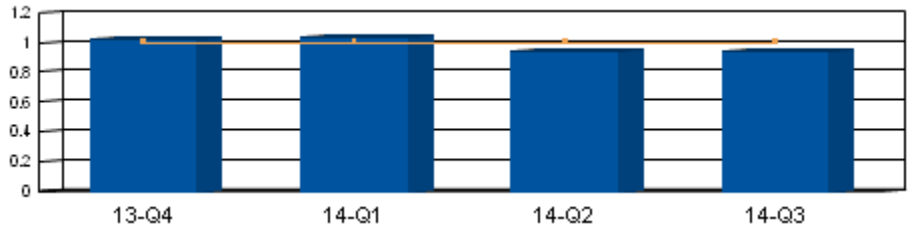
Actions & Monitoring Underway to Improve Performance:

Considerable testing done through a number of blitzes however additional staff expired. Currently working to develop electronic self-scheduling capability for staff to schedule in their fit test.

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

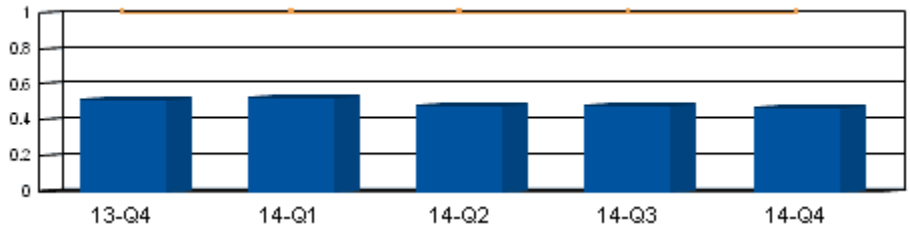


	Actual	Target
14-Q1	1.03	**≤1**
14-Q2	0.94	**≤1**
14-Q3	N/A	**N/A**
14-Q4	N/A	**N/A**

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 - 2010



	Actual	Target
13-Q4	0.51	**≤1**
14-Q1	0.52	**≤1**
14-Q2	0.48	**≤1**
14-Q3	0.47	**≤1**
14-Q4		**≤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

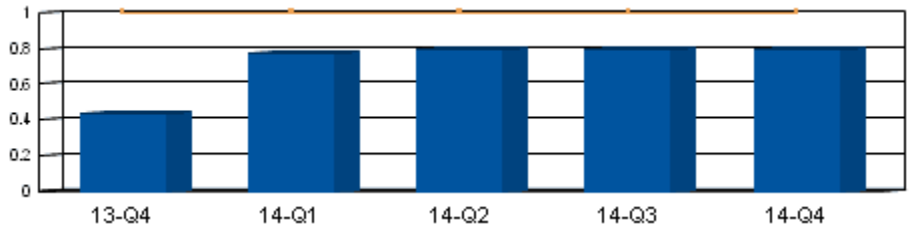
Kingston General Hospital

Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - WSIB NEER Performance Index - 2011

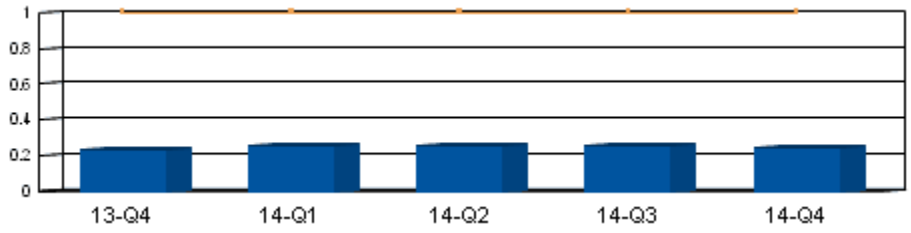


	Actual	Target
13-Q4	0.44	**≤1**
14-Q1	0.77	**≤1**
14-Q2	0.80	**≤1**
14-Q3	0.80	**≤1**
14-Q4		**≤1**

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

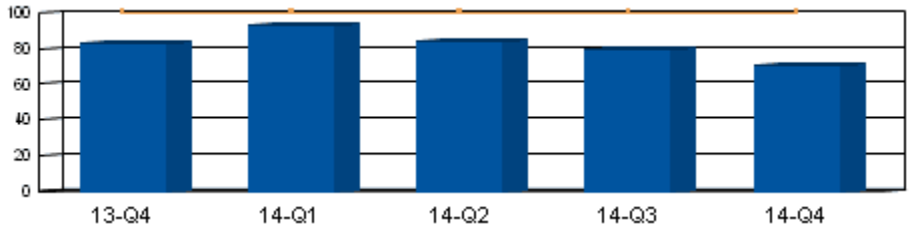


	Actual	Target
13-Q4	0.23	**≤1**
14-Q1	0.26	**≤1**
14-Q2	0.25	**≤1**
14-Q3	0.24	**≤1**
14-Q4		**≤1**

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 - Incident Investigations Complete



	Actual	Target
13-Q4	83	**100**
14-Q1	93	**100**
14-Q2	84	**100**
14-Q3	80	**100**
14-Q4	71	**100**

Interpretation - Patient And Business:

Overall completion for the fiscal year was 82%
Q1- 93%, Q2- 84%, Q3- 80%, Q4- 71%

Upgrade to Safe Reporting and changes made to incident investigation template likely a factor in reduced completion in Q4.

Actions & Monitoring Underway to Improve Performance:

Effective April 1, 2014, Safety Advisor & Ergonomist in OHSW to support Management in the completion of Incident Investigations for incidents that result in WSIB healthcare and lost time injury claims.

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%

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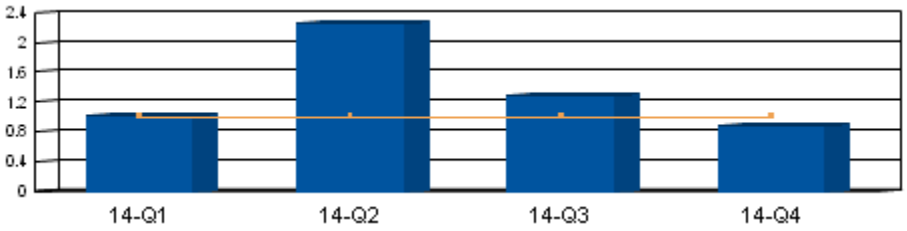
Indicator: OHS - Lost Time Severity Rate (Days Lost/100 Workers)



	Actual	Target
14-Q1	1.03	**≤1**
14-Q2	2.27	**≤1**
14-Q3	1.30	**≤1**
14-Q4	0.88	**≤1**

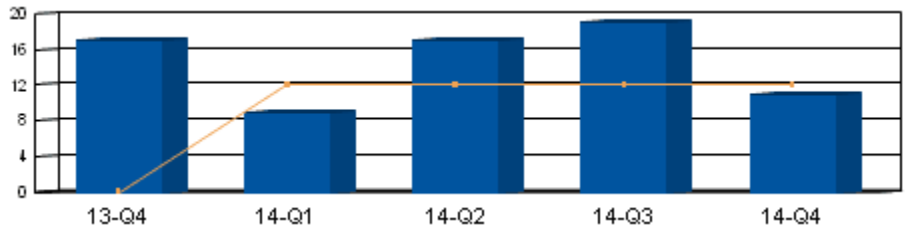
Interpretation - Patient And Business:

Total lost days for the quarter was 39; 3 of these days were related to 2 claims; the other 33 days were related to a 2013 violence related injury in an ED employee that required surgery in January of 2014.

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

Target: Target 2013/14: 0

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



	Actual	Target
13-Q4	17	**0**
14-Q1	9	**≤12**
14-Q2	17	**≤12**
14-Q3	19	**≤12**
14-Q4	11	**≤12**

Interpretation - Patient And Business:

Q4- 11 NSIs occurred- this is a 40% reduction from Q3.

Annual incidence of NSIs was 56 (with a goal of 49) or less. Programs with highest annual incidence of NSIs were: Medicine (23%), SPA (21%), and Critical Care (14%).

Actions & Monitoring Underway to Improve Performance:

Needle Safety awareness training for clincial staff to be launched May 2014

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

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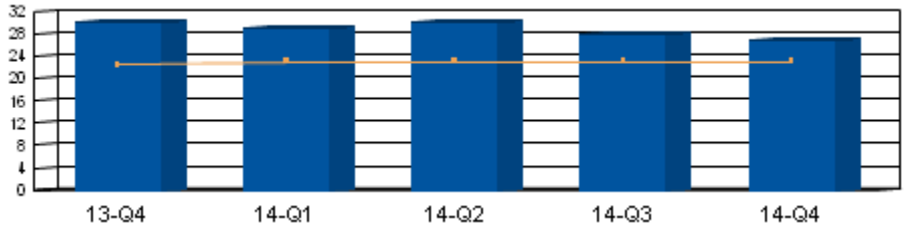
Indicator: OHS - Total MSI Incidents



	Actual	Target
13-Q4	30	≤23
14-Q1	29	≤23
14-Q2	30	≤23
14-Q3	28	≤23
14-Q4	27	≤23

Interpretation - Patient And Business:

Q4- 44% of MSIs were related to patient handling with highest incidence in the Medicine Program; 36% of non-patient handling MSIs occurred in Environmental Services. 2 MSIs in Q4 resulted in lost time and 6 resulted in WSIB healthcare claims

Annual MSI incidence = 115 (Goal was 90 or less).

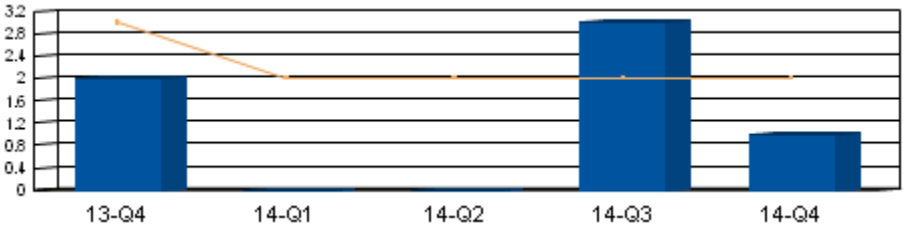
Actions & Monitoring Underway to Improve Performance:

Effective April 1, 2014, rather than reporting only on the number of MSI-related safe reports, we will meaure MSI severity as this is likely a better indicator of our progress with reducing MSIs.

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

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

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



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

Interpretation - Patient And Business:

In Q4, 1 MSI resulted in lost time in the ED.

Annual total of MSIs resulting in lost time was 4 with a goal of 10 or less.

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

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

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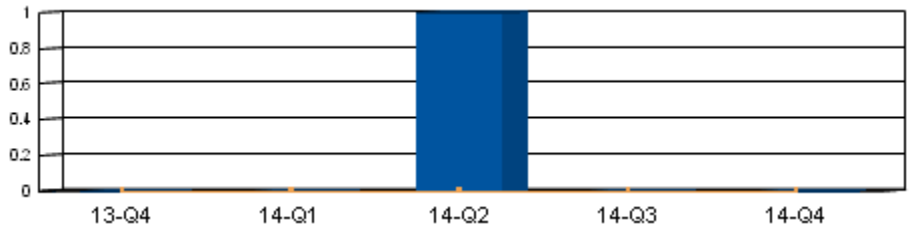
Indicator: OHS - MOL Reported Critical Injury Incident



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

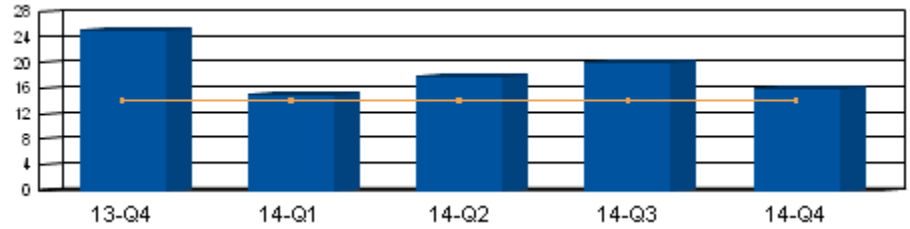
Interpretation - Patient And Business:

No critical injuries Q4; overall 1 critical injury this fiscal year which occurred in Q2 and was the result of a fall.

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-Q4	25	**<14**
14-Q1	15	**<14**
14-Q2	18	**<14**
14-Q3	20	**<14**
14-Q4	16	**<14**

Interpretation - Patient And Business:

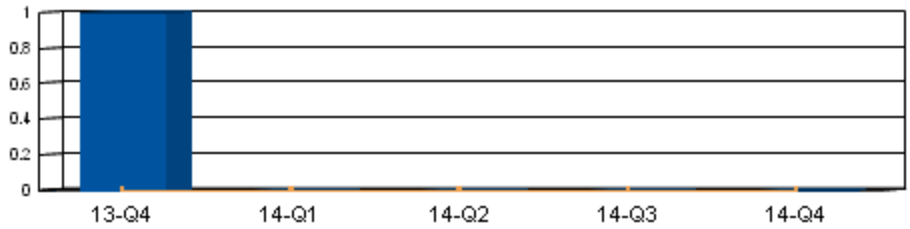
Highest occurrence in in Medicine (25%) and Critical Care (19%). Most common causes of healthcare claims were Caught in/by/Struck by/against injuries (38%) and non-patient handling MSIs (25%).

Annual incidence of health care claims was 68 (Goal was 54 or less).

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

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

Indicator: OHS - Occupational Illness Reported to MOL



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

Interpretation - Patient And Business:

No occupational illness however a TB exposure occurred in Feb 2014 that has resulted in baseline and follow up TB skin testing on +150 staff in the ICU's, ER and Connell 10.

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:

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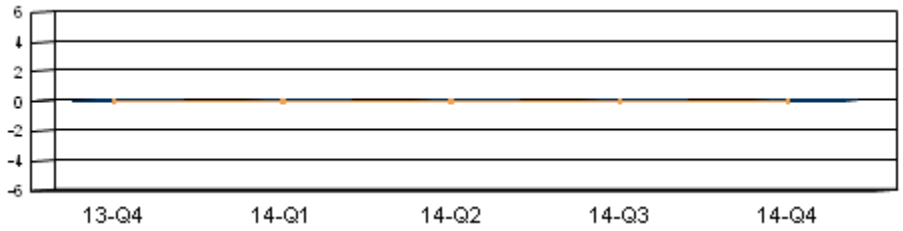
Occupational Health and Safety Scorecard

Health and Safety

Health & Safety

Indicator: OHS - MOL Orders Issued During Site Visit



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

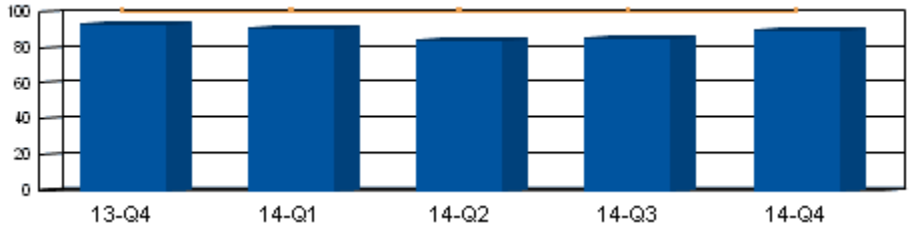
Interpretation - Patient And Business:

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-Q4	93	**100**
14-Q1	91	**100**
14-Q2	84	**100**
14-Q3	85	**100**
14-Q4	90	**100**

Interpretation - Patient And Business:

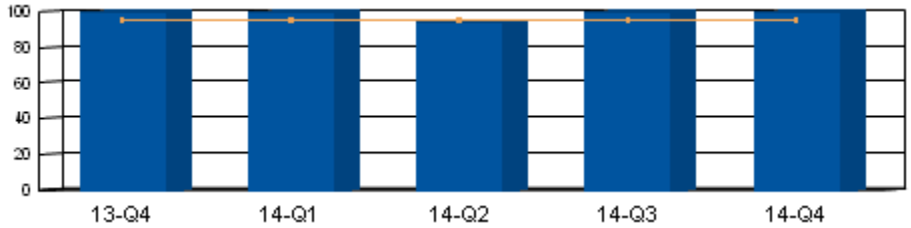
As of end of Q4:

Workplace Violence Prevention- 98%
MSI Prevention- 94%
WHMIS- 94%
Safety Talks- 73%

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

Target: Target 2012/13: 100%

Indicator: OHS - Pre-Placement Health Screening Completed



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

Interpretation - Patient And Business:

Overall 99% for the fiscal year:

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