fiscal 2014-2015 **Q1**

1st quarter ended June 30, 2014

KGH this quarter

Strategy Performance Report

Kingston General Hospital

Outstanding care, always

KGH Strategy Performance Report Fiscal 2015 Q1

KGH Strategy Performance Report Fiscal 2015 Q1

Strategic Direction 2

Bring to life new models of interprofessional care and education

Outcome 4:

Our Interprofessional Collaboration Practice Model (ICPM) is implemented in every clinical are with high ratings from patients, staff and learners

Strategic Performance Indicators

Strategic Direction 3

Bring to life new models of interprofessional care and education

Outcome 5:

Externally funded research at KGH has increased 50%

Strategic Performance Indicators

Strategic Direction 4

Increase our focus on complex-acute and specialty care

Outcome 6:

KGH services are well aligned and integrated with the broader health care system

Strategic Performance Indicators

Strategic Direction 5

People

Outcome 7:

Staff are engaged in all aspects of our quality, safety, and services improvement initiatives

Strategic Performance Indicators

KGH Strategy Performance Report Fiscal 2015 Q1

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

Strategic Direction	2015 Outcome	Indicator	14-Q1	14-Q2	14-Q3	14-Q4	15-Q1	
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	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	G	G	N/A	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	R	G	Y	G	↑
		Hand Hygiene Compliance - (QIP)	Y	R	R	R	R	↓
		Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)	N/A	N/A	N/A	N/A	G	
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	G	G	G	G	N/A	↑
		Medication Reconciliation at Admission (QIP)	R	R	R	R	R	↑
		Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)	Y	Y	R	R	Y	↑
		Number of Incidents Associated with Morphine or Hydromorphone	N/A	N/A	N/A	N/A	R	
		Number of Specimen Collection and Labelling Errors	N/A	N/A	N/A	N/A	R	
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	R	G	G	G	G	↑
	All preventable delays in the patient journey to, within, and from KGH are eliminated	90th Percentile ED Wait Time - All Admitted Patients (Hrs.) - (QIP)	R	Y	R	R	R	↓
		Percent ALC Days (QIP)	R	R	R	R	R	↓
		Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding 90th Percentile Wait Time Targets	R	R	Y	R	R	↓
		Overall Medical/surgical Occupancy Rate (Midnight Census)	N/A	N/A	N/A	N/A	Y	
		OR Cancellation Rate	Y	Y	G	G	Y	↑

Strategic Direction	2015 Outcome	Indicator	14-Q1	14-Q2	14-Q3	14-Q4	15-Q1	
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 Compliance within Each of the 5 Standards across Clinical Areas	N/A	N/A	N/A	N/A	G	
Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	Research Joint Venture Project Implementation Plan Is Meeting All Quarterly Milestones	N/A	N/A	N/A	N/A	G	
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	Readmission Rate within 30 Days for Selected CMG's to Any Facility (QIP)	Y	R	N/A	N/A	N/A	↓
People	Staff are engaged in all aspects of our quality, safety, and service improvement initiatives	Quarterly Engagement Plan Status	N/A	N/A	N/A	N/A	Y	
		Number of Staff with Performance Reviews and Agreements on File	N/A	N/A	N/A	N/A	Y	
	All preventable harm to staff is eliminated	Number of WSIB Health Care and Lost Time Injury Claims due to MSI	N/A	N/A	N/A	N/A	R	
		Number of Needlestick Injuries	G	R	R	G	G	↑
Facilities	Phase 2 construction is under way and KGH is clean, green, and carpet free	Percent Compliance with Cleaning Audits	Y	Y	Y	Y	Y	↑
		Stage 2 Approval Status	Y	Y	R	R	Y	↑
Technology	Rapid transmission of information improves care and operational efficiency	Regional Health Information System Planning Process is Meeting all Quarterly Milestones	N/A	N/A	N/A	N/A	G	
Finances	Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures	Total Margin (QIP)	G	G	G	G	G	↑
		Total Dollars for Capital Equipment, Technology and Infrastructure ($000's)	Y	Y	Y	G	Y	↑

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

Strategy Indicators

	#	%
Red	9	33%
Green or Yellow	18	67%
N/A	0	0%
	27	

QIP Indicators

	#	%
Red	5	42%
Green or Yellow	7	58%
N/A	0	0%
	12	

Supporting Indicators

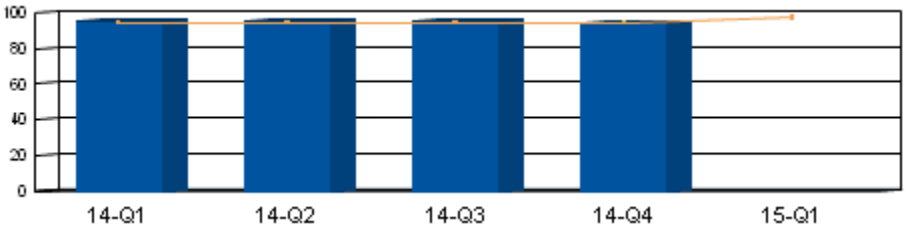
	#	%
Red	23	28%
Green or Yellow	54	65%
N/A	6	7%
	83	

Strategy Performance Report Fiscal 2015 Q1

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

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



	Actual	Target
14-Q1	95	**94**
14-Q2	95	**94**
14-Q3	95	**94**
14-Q4	94	**94**
15-Q1		**97**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

KGH has licensed Communicate with H.E.A.R.T which is a service excellence program created by the Cleveland Clinic. Communicate with HEART uses a common sense approach of interacting with others. It's a healthcare-focused model that will provide all KGH staff, along with volunteers and physicians with the practical knowledge to help them address patient concerns. It will also help staff to communicate with patients, families and coworkers with empathy. By engaging our patients with consistent empathetic communication, we hope to address any concerns or question a patient or their family experiences over the course of their care. We hope patients will as a result feel more positive about their experience with KGH.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

41 KGH employees, volunteers, and Patient Experience Advisors have already been trained as facilitators to help roll out this program across the hospital. Training will officially begin in September 2014 with the goal of having all KGH staff, Patient Experience Advisors, volunteers, and credentialed staff educated in this standard by December 2016.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

There is a stretch goal for improving the overall patient satisfaction by 2%. We have targeted the training program to the medicine program with the hope of having significant impact on patient satisfaction within that group. We believe we are on target to achieve this target by year end.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong STRATEGY REPORT

The patient's perception of overall care received and is based on a single question (#44) on the National Research Corporation of Canada (NRCC) Acute Inpatient 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.
Ambulatory Care is reported separately, with Oncology reported bi-annually and Emergency Care reported quarterly.

Target: Target 12/13: PTAOB, Target 13/14: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%,Target 14/15: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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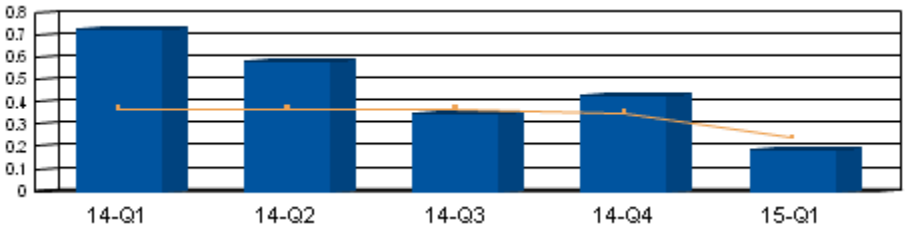
Indicator: C-Difficile (Reported Quarterly) (QIP)



	Actual	Target
14-Q1	0.73	**0.37**
14-Q2	0.58	**0.37**
14-Q3	0.35	**0.37**
14-Q4	0.43	**0.35**
15-Q1	0.19	**0.24**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Tactics: ongoing focus on early identification of suspected cases and isolation; C diff preprinted order sheet implementation; Infection control team education on wards: all implemented and doing well. Expansion of the antibiotic stewardship program to all critical care areas is underway.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The KGH rate for this quarter was 0.19 cases per 1000 patient days; a decrease from the fourth quarter. In April we identified 2 cases of nosocomial CDI. In May we identified 4 cases and in June there was only 1 case identified, giving us a total of 7 cases for this quarter. In Quarter 4 of 2013 - 2014, we had 16 cases; in Quarter 3, 27 cases; in Quarter 2, 21 cases and Quarter 1 2013 - 2014, 13 cases.

We continue a steady downward trend in CDI cases, which has been sustained for > 2 years. Multiple factors continue to contribute to the organization's ability to sustain this marked improvement.

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.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

Definition: DATA: Darlene Campbell COMMENTS: Dr.Gerald Evans STRATEGY REPORT

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, Target 14/15: 0.24 Perf. Corridor: Red >0.26 Yellow 0.25-0.26 Green <=0.24

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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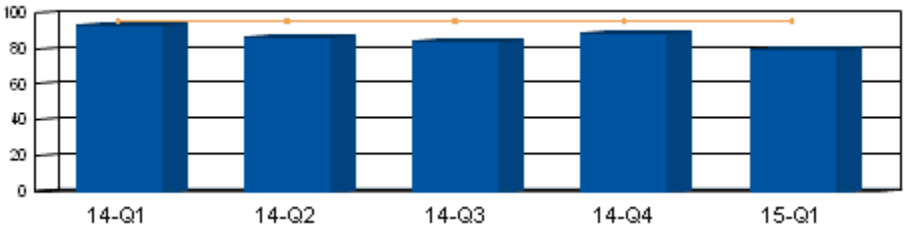
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
14-Q1	93.0	**95**
14-Q2	86.3	**95**
14-Q3	83.7	**95**
14-Q4	88.2	**95**
15-Q1	79.7	**95**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

IPAC Service continues to train and support new hygiene auditors recognizing the time it takes to become skilled with the device and how to identify and capture all hand hygiene opportunities. We are establishing a Hand Hygiene Working Group to discuss and determine opportunities for us to increase and sustain the improvements to our compliance with our Hand Hygiene Program.

For this quarter we captured 1843 indications of Moment 1(before initial patient/patient environment contact). KGH's 2013 -2014 annual total for Moment 1 were 5466 indications. 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%.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

While many units are performing well above 80%, data shows isolated areas/units in the hospital are seeing unacceptably low rates of compliance (50 - 60%). The impact is putting patients at risk of nosocomial infection with risk of serious morbidity and mortality. Although July data has seen a rise above 80%, it is short of the target of 95%.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

No. The current Q1 result has fallen significantly and falls short of expectations. Infection Prevention and Control has formed a working group to urgently address the situation. Tactics and plans will come to the Patient Safety and Quality Committee in September. A refresh of the corporate awareness will be undertaken stating that anything less than 100% compliance is unacceptable. There will be an increased focus on accountability for unit, ward or provider group performance by the respective leadership.

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

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.
Links to Outcomes & Initiatives:
Clinical Quality & Outcomes: Patient Safety, Care Pathways and Practice and Interprofessional Collaborative Practice Model (ICPM).

Target: Target 11/12: 90% Target 12/13: 95%, Target 13/14: 98% Perf. Corridor: Red <90% Yellow 90%-95% Green >=95%,Target 14/15: 95% Perf. Corridor: Red <90% Yellow 90%-94% Green >=95%

Strategy Performance Report Fiscal 2015 Q1

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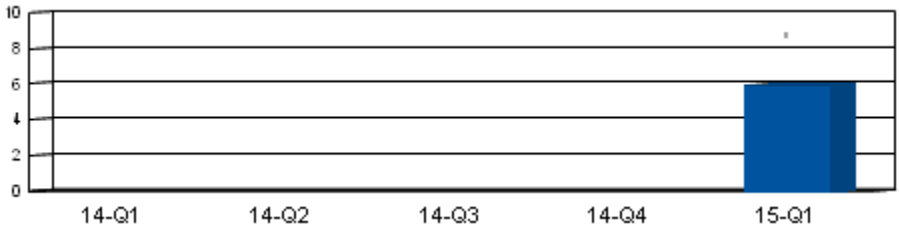
Indicator: Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)



	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	5.9	**8.68**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

All 5-day in hospital mortalities are reviewed similar to the standard mortality process. Concerns/issues are reviewed at JQUIC.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The current death rate is below the provincially set target.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

Definition: DATA: Decisions Support COMMENTS: David Zelt STRATEGY REPORT

The rate of the in-hospital deaths due to all causes occurring within five days of major surgery.

Target: Target 14/15: 8.68 Perf. Corridors: Red <10% Provincial Rate Yellow Within 10% of Provincial Rate Green >= Provincial Rate

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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

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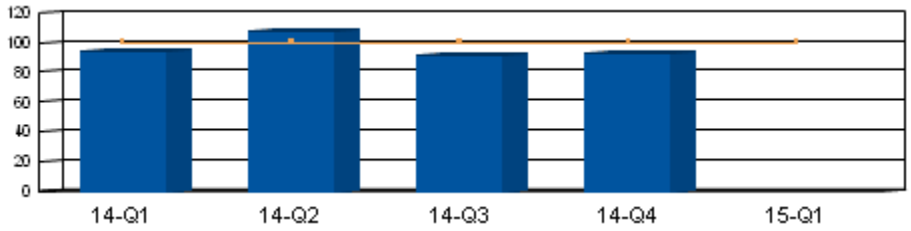
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
14-Q1	94	**100**
14-Q2	107	**100**
14-Q3	92	**100**
14-Q4	93	**100**
15-Q1		**100**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

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. Currents tactics underway to address the HSMR are as follows: Mortality reviews in all KGH clinical departments (Medicine - focus on Sepsis, Surgery - all plus post major surgery, other Departments - all deaths), application of the VAP prevention protocol including a checklist, and conducting MRSA admission screening on all admissions.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The most recent data available data from CIHI is Q4 of fiscal 13/14. The HSMR for Q4 was deemed not significant by the Canadian Institute for Health Information (CIHI). 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.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

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

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, Target 14/15: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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

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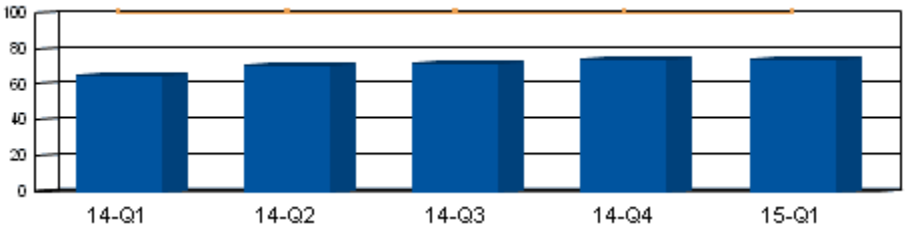
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
14-Q1	65	**100**
14-Q2	70	**100**
14-Q3	72	**100**
14-Q4	74	**100**
15-Q1	74	**100**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The Fiscal 2014/15 Q1 medication reconciliation on admission indicator value of 74% is below the goal of 100%.
In Fiscal 2014/15 Q1, Clinical Pharmacy adopted the following tactic: "100% of patient care medical services have an admission pre-printed order set embedding the medication reconciliation on admission process".

As a first step, medical services that do not have an admission order set were identified with plan to initiate dialog with the Department heads.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The percentage of patients who receive medication reconciliation at admission has increased throughout Fiscal 2013/14 from 65% (Q1) to 74% (Q4). Fiscal 2014/15 Q1 results indicate the process improvement is sustained at 74%. Performing medication reconciliation on admission supports patients having a Best Possible Medication History gathered at admission and medication discrepancies avoided or resolved on admission, supporting the prevention of patient harm during hospitalization.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Although compliance with medication reconciliation at admission has improved over the past 3 years, the Fiscal 2014/15 Q1 indicator is still well below the year end goal of 100%.
The following Pharmacy tactics are planned in Q2 and Q3 to ensure the target is met: 1) ensure availability of admission order sets on surgical patient care units; 2) attend Department of Surgery meeting to engage physicians; and 3) develop a medication reconciliation administrative policy.

Definition: DATA: Decision Support COMMENTS: Veronique Briggs STRATEGY REPORT

The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital.

Target: Target 14/15: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

Strategy Performance Report Fiscal 2015 Q1

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

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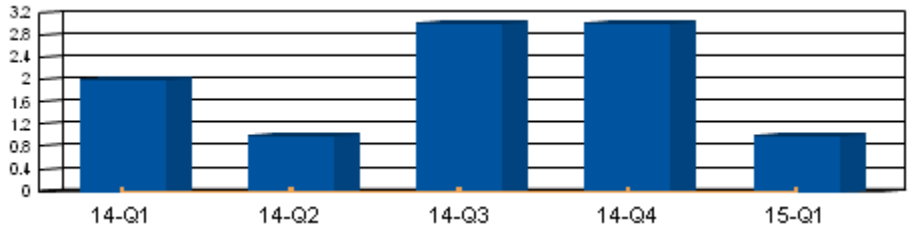
Indicator: Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Our aim is to transform the patient experience by eliminating all preventable harm to patients' specifically patient falls. All patient falls present a risk of injury. Hospitalization increases risk of falls due to an unfamiliar environment, illness and medication side effects. Through falls risk identification and frequent early mobilization of all patients we are proactively addressing patient falls. The Falling Star program focuses on the assessment, documentation, communication and knowledge of patient risk. Move ON focuses on the increased frequency of safe mobilizations of patients. Education on both programs was successfully delivered to all clinical area implementation teams by end of Quarter 1.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

We had one actual severity level 3 (moderate harm) fall in Q1 whereby the patient sustained an injury requiring medical intervention. This resulted in an extended length of stay.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We are on track to meet our end of Q2 target which is full implementation of both Move ON and Falling Star programs on all clinical units. Q3 and Q4 is our sustainability phase which includes will include an auditing process.

Definition: DATA: Decision Support COMMENTS: Astrid Strong STRATEGY REPORT

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. Our aim is to eliminate actual level 3 (moderate harm) and level 4 (severe/critical harm) patient falls.

Target: Target 13/14: 0 Perf. Corridor: Red >3 Yellow 1-3 Green 0,Target 14/15: 0 Perf. Corridor: Red >3 Yellow 1-3 Green 0

Strategy Performance Report Fiscal 2015 Q1

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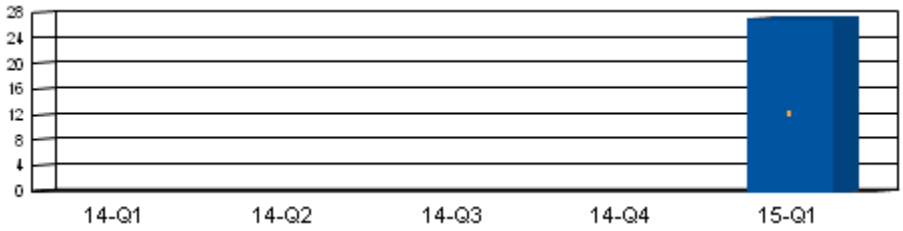
Indicator: Number of Incidents Associated with Morphine or Hydromorphone



	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	27	**12**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Twenty-seven reported medication administration incidents associated with morphine or hydromorphone is above the target of 12 for this quarter.
As KGH continues to implement automated dispensing cabinets (ADCs) throughout the hospital, morphine and hydromorphone will be dispensed via ADCs. At the end of Fiscal 2014/15 Q1, the ADC project is at 63% completion.
A Quarterly Safe Reporting System report is now available for hydromorphone and morphine. The Medication Safety Committee is planning to review the incidents and investigate safeguards for hydromorphone.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The plan to achieve a 50% reduction in the incidence of hydromorphone and morphine medication incidents through the implementation of ADCs has not achieved in Q1.
Among the 27 reported medication administration incidents, the majority involved hydromorphone (21) compared to morphine (4) with 2 incidents involving the administration of hydromorphone when morphine was ordered. Incidents included incorrect dose/strength, incorrect frequency, incorrect medication, incorrect patient, incorrect route, and administration omission.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The use of ADCs can enhance the safety of administration of high alert medications (hydromorphone and morphine) when locked in a single-product drawer and a pharmacist review of the order has taken place prior to medication administration.
Medication incidents should decrease as the dispensing of hydromorphone and morphine via ADCs increase. ADC installation is ongoing with planned completion at the end of Q3.

A new tactic planned for Q2 and Q3 is to investigate and implement safeguards for hydromorphone. Safeguards may include: Optimize pharmacy order review and entry before administration, dispense unit-doses of medications, restrict critical overrides, and use automated independent double checks, screen alerts, “witness to override” or clinical prompts functions. The Medication Safety Committee will lead this tactic with careful review of the location, types and root causes of the reported incidents.

Definition: DATA: V. Briggs COMMENTS: V. Briggs STRATEGY REPORT

The total number of reported medication incidents associated with HYDROmorphone and morphine.

Target: Target 2014/15: 12 Perf. Corridor: Red >20 Yellow 16-20 Green <=15

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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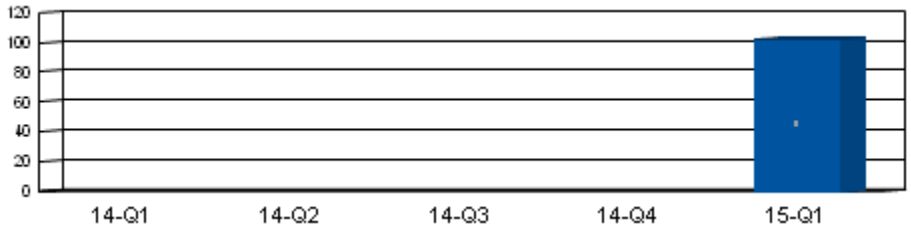
All preventable harm to patients is eliminated

Indicator: Number of Specimen Collection and Labelling Errors



	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	102	**45**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

When the "six" rights of specimen collection are followed (the right patient,requistion,test,collection, tube and labelling" there will be a significant reduction in the number of mislabeled specimens sent to the clinical laboratory for testing. Laboratory results are used to screen for disease states, monitor disease states or to diagnose a disease state. Incorrect specimen collections have an impact on the organization not only from a financial perspective but patient satisfaction and risk perspective as well. Ongoing education is taking place regarding the importance of reporting incidents in the SAFE reporting system which then will allow for opportunity for staff education. Reports are being generated to identify patterns of incidents by unit or individuals again to educate or to review systems or processes. Preliminary work underway to roll out a LMS (learning module) around patient identification. A laboratory PreAnalytical Manager has been hired (will start Sept. 2014) who will focus on specimen collection, specimen quality as well as rolling out the phlebotomy team. All tactic work plans are in progress.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Goal being to reduce the number of specimen collection and labelling errors by 75% from last fiscal year. This means an overall reduction of errors from 225 per quarter in Fiscal 2014 to the goal of 45 collection errors by end of Fiscal 2015. An incremental reduction of 25% per quarter is the strategy, This indicator is on track.

A reduction in specimen collection errors will prevent delays in care plans and improve the patient experience. There will be a reduction in unnecessary testing which will reduce lab costs.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are on track to meet the target by year end. There will be an incremental decrease by 25% each quarter for an overall 75% reduction in errors to reach the target of 45 by end of Fiscal 2015.

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

The accurate identification of patients and specimen labeling is integral to patient safety.
When the "six rights of specimen collection" (the right patient, right requisition/order entry, right test, right order of draw, right tube and right labelling) are followed there will be a significant reduction in the number of mislabeled specimens sent to the clinical laboratory.

Target: Target 2014/15: 45 Perf. Corridors: Red >75 Yellow 56-75 Green <=55

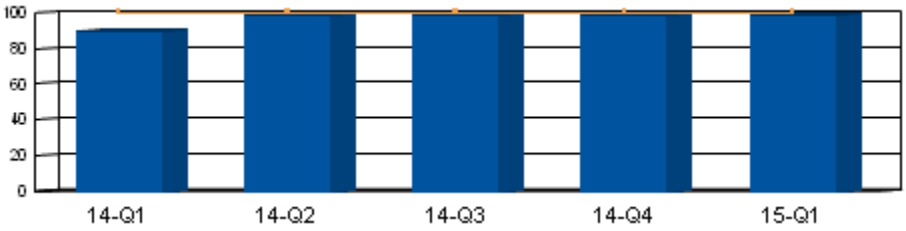
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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

All preventable harm to patients is eliminated

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



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The review of the Surgical Safety Checklist metrics by the working group continues to influence the ability to successfully meet this target. This quarter the creation of a new pediatric and orthopedic specific surgical safety checklist was completed and is to be implemented for the next quarter.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

For Q1 this indicator continues to meet the green target corridor. There were 2,285 surgical cases completed in this quarter. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.5%, Timeout-99.5%, and Debrief- 99.7%.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The program is on track to continue meeting the target by year end.

Definition: DATA: Kathleen Wattie Barnett COMMENTS: Kellie Kitchen STRATEGY REPORT

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.

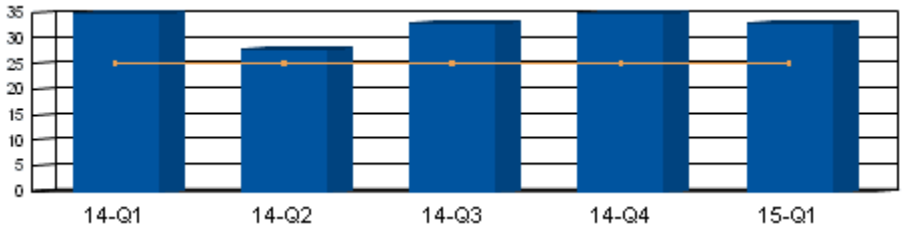
Target: Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%

Strategy Performance Report Fiscal 2015 Q1

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

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



	Actual	Target
14-Q1	35	**25**
14-Q2	28	**25**
14-Q3	33	**25**
14-Q4	35	**25**
15-Q1	33	**25**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Work continues on addressing the opportunities identified as the top sources of gridlock. Working groups are looking at consultant arrival times and processes around decision to admit as priorities for improvement as well as minimizing bed empty time. All consulting services have been provided with data specific to their service and asked to make a 20% improvement in disposition decision. Projects have been implemented to standardize the discharge process. The Patient Flow Task Force has oversight of these initiatives and receives updates twice a month.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The Q1 result of 33 hours is 8 hours longer than the 25 hour target. Ninety percent of all patients admitted through the ED waited up to 33 hours to be transferred to an inpatient bed. Ten percent waited longer than this. Based on Q1 admission volumes of 2854, 285 patients waited longer than 33 hours in the ED for an inpatient bed. Inpatient days in the ED are 882 which is the equivalent of 10 beds. This has a negative impact on the ability to see, assess and treat other patients within the recommended time. 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. LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Uncertain at the end of Q1. If trend continues we will not meet the target. However, with the re-commission of Inpatient beds with the new bed map in Q2, it is expected to help minimize the delays in transferring patients to inpatient beds with the potential of meeting the target by the end of the year.

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

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.

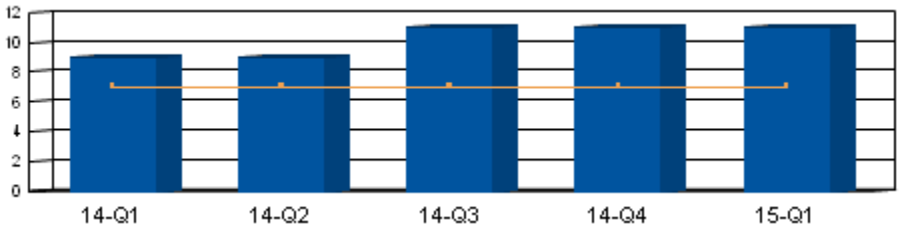
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28

Strategy Performance Report Fiscal 2015 Q1

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

Indicator: Percent ALC Days (QIP)



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The tactic is to develop a working group to reduce the number of patients admitted with a primary ALC status. All patients designated ALC were reviewed for timing of designation. In the first quarter there were only two patients designated ALC within 72 hours of admission. Both of these cases were designated ALC for Rehab and were appropriate designations based on expected course of treatment. There were no designations of ALC for long term care made at time of, or shortly after, admission. The working group has not yet been formally implemented. This is planned for Q2

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This indicator is described as the percentage of inpatient days that a patient occupying an acute care hospital bed has finished the acute phase of his/her treatment. The total number of ALC days is influenced by both the number of ALC patients and their ALC-specific lengths of stay.

The Q1 result of 11% indicates that, on average, there were more than 40 inpatients at KGH whose acute care stay was complete and who were waiting for access to one of the destinations listed below.

A high number of ALC days generally reflect 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 majority of ALC patients are awaiting transfer to a long term care home (LTC). Although the average number of ALC-LTC patients are holding steady at approximately 30, the average length of stay i.e. wait time for access to a LTC bed is climbing. On average these patients are waiting in excess of 120 days for transfer. In addition to clinical-based barriers to transfer (behavioral, equipment, etc.) community crisis placements continue to delay the ALC-LTC flow.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

It is uncertain as to whether or not we will achieve the target of 7% ALC Days for fiscal 2015.

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.

Daily meetings regarding patient flow and opportunity to access destinations outside of KGH will occur starting in Q2. These meetings and discussions include all of our SELHIN partner hospitals, CCAC and others as applicable. Weekly discussions are ongoing and will be formalized in Q2 for the very complex patient discharges with a purpose to pursue elimination to barriers to discharge.

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 STRATEGY REPORT

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.

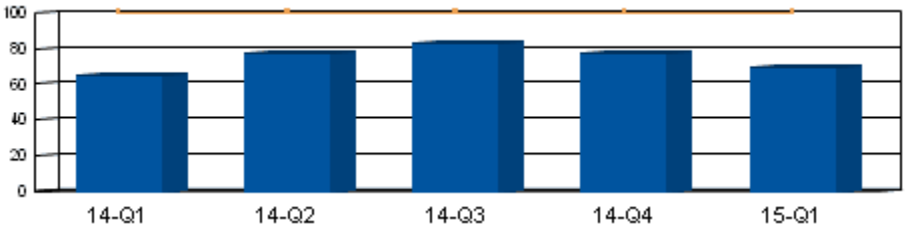
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%

Strategy Performance Report Fiscal 2015 Q1

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

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



	Actual	Target
14-Q1	65	**100**
14-Q2	77	**100**
14-Q3	83	**100**
14-Q4	77	**100**
15-Q1	69	**100**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Develop a work plan to implement new wait time monitoring and work flow that meets new Ministry reporting requirements. The Ministry is moving away from measuring wait times at the 90th percentile and introducing new metrics that measure the percent of completed cases by urgency score.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

There has been a slight decrease in the number of services meeting the 90th percentile wait time target in Q1. 16 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; 4 orthopedic; 2 plastics, 3 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

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

Definition: DATA: Decision Support COMMENTS: John Lott STRATEGY REPORT

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 across a number of unique categories to the MOH on a monthly basis. This performance indicator simply counts the number of those unique categories (Excluding Cancer Surgery) 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 12/13: 90%, Target 13/14: 100% Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%, Target 14/15: 100% Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

Strategy Performance Report Fiscal 2015 Q1

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

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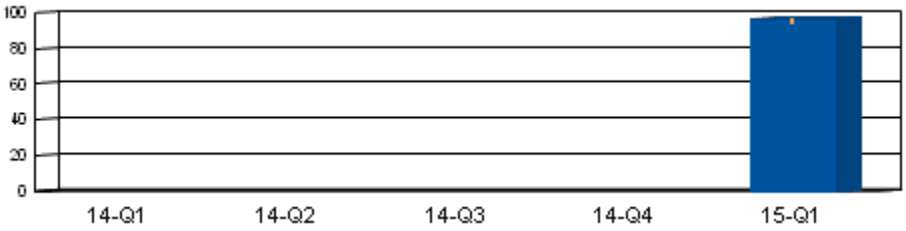
Indicator: Overall Medical/surgical Occupancy Rate (Midnight Census)



	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	96	**95**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The current Q1 overall medical/surgical occupancy rate of 96% is slightly above the target of 95% which was set in Q4 of last year when the medical/surgical rate was at 98%. Therefore, there has been an improvement of 2% The overall decrease in occupancy may be attributed in part to continued work with length of stay, discharge planning; however it must be noted that there is disparity between the occupancy rates of the various programs with Medicine consistently being above 100% (average for Q1 was 107%). As well there is variation within programs such as SPA with high occupancy Monday to Friday and lower occupancy on weekends. The overall occupancy is expected to be further reduced with full implementation of the proposed bed map in Q3 of this year.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Work has been focused on enhancing occupancy reporting to reflect the proposed bed map and to better support bed utilization, bed occupancy reporting and decision making. This information is shared at a program level as well as at a corporate level. Q1 has also seen very detailed budget and staffing planning to support the implementation of the proposed bed map - work overseen by a Bed Implementation Team. Notice to unions is expected in Q2 with full implementation of the map by end of year. Attention will also need to be given to strategies that lead to leveling of occupancy on a 7 day basis.

Work also continues with transition of patients designated as ALC (sub-acute medical and surgical as well as in the mental health inpatient unit) as these are strategies aligned to optimal use and occupancy of acute care beds.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes

Definition: DATA: Decisions Support COMMENTS: Eleanor Rivoire STRATEGY REPORT

Bed occupancy is an important efficiency indicator for hospitals. Optimal medical/surgical occupancy is said to be at approximately 85%, allowing for appropriate staffing ratios and the potential to surge as required. As occupancy rises, inefficiencies appear with respect to patient flow leading to prolonged lengths of stay as well as having a negative impact of patient safety, quality and risk.

Target: Target 14/15: 95% Perf. Corridors: Red >=100% or <=90% Yellow 96%-99% or 90%-94% Green =95%

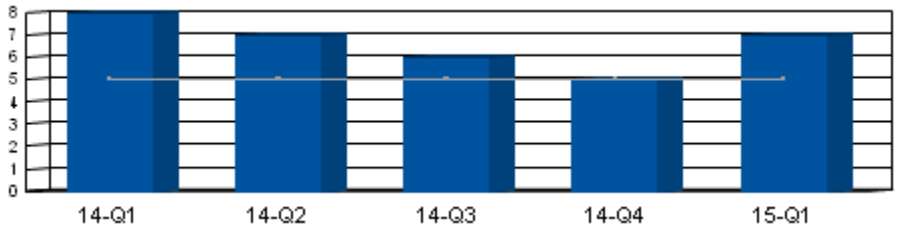
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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

Indicator: OR Cancellation Rate



	Actual	Target
14-Q1	8	**5**
14-Q2	7	**5**
14-Q3	6	**5**
14-Q4	5	**5**
15-Q1	7	**5**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The establishment of the OR Cancellation working group and the development of tactics to influence avoidable cancellations have been created for implementation in the next quarter. These tactics include:
1) Quarterly meetings with secretarial office staff and program leadership
2) Quarterly newsletter with updated volumes and wait time metrics to support office monitoring of bookings
3) Creation of one resource person for office staff support
4) Patient follow-up calls at one week and night before surgery
5) Patient communication letter highlighting OR surgery preparation sent out by secretarial office staff

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

This quarter there were 161 out of 2,285 patients whose surgeries were cancelled. Within this volume there were 35 avoidable cancellations that if identified earlier (instead of the day of surgery) could have been assigned to other patients. These cancellations included: surgery already done-1, equipment broken-1, incomplete presurgical screening-1, incorrectly booked-7, patient not fasting -2, patient refused procedure-5, patient unavailable-2, surgeon unavailable-1, surgery no longer required-2, surgeon decision-1, and change in medical condition after their presurgical screening visit- 12. Also influencing the performance for this quarter was the 4 episodes of "Code Gridlock" lasting 174.5 hours resulting in the cancellation of 4 patients as well as an environmental crisis (OR room) causing the cancellation of 6 additional patients.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

With the implementation of the new tactics the program will be on track in reducing avoidable cancellations. The unpredictability of gridlock events and unanticipated earlier case complications or emergency case substitutions will influence this metric on a quarterly basis towards achieving the year-end target.

Definition: DATA: Kellie Kitchen COMMENTS: Kellie Kitchen STRATEGY REPORT

The rate which is the number of surgeries cancelled divided by the number of surgeries completed (as per SETP)

Target: Target 14/15: 5% Perf. Corridors: Red >9 Yellow 7-9 Green <6

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

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

Indicator: Percent Compliance within Each of the 5 Standards across Clinical Areas

	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	94	**100**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Five Patient- and Family Centered Care standards have been adopted at KGH with some being applicable to support/service areas and all being applicable to inpatient units. Standards include patient led feedback forums (discharged patients/families return to unit to discuss their hospital experience with staff and determine what needs to be supported and what needs to be remedied for the best patient experience. Improvement cycles are initiated after each forum), ID badges worn at chest level, patient whiteboards completed at every shift change, communication (staff introducing themselves to patients and families and saying why they are there) and purposeful hourly rounding (each patient is seen by a staff member at least every hour). An online education module instructing on the 5 standards has been created and is required of each staff member, and a process of conducting audits, including reporting to programs, has been developed and implemented.
Each program is expected to complete a minimum of 2 feedback forums and 4 improvements per year. For the other 4 standards managers complete audits each month on each of their units for each of the standards. There are also general audits which take place randomly across the organization. If a unit/service or department is not achieving the expected 85% compliance rate with a standard the director/manager is alerted and support with education is provided to increase compliance.

In support of the Communication standard a work plan has been developed for roll out of H.E.A.R.T. (Hear, Empathize, Apologize, Respond, and Thank) and is in process of implementation. H.E.A.R.T. is a communication tool which will provide staff and physicians the skill set to better engage patients, families and each other. 40 KGH trainers received training from Cleveland Clinic (creators of the program) staff and are preparing the roll-out to all staff and physicians.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

A total of 18 feedback forums are expected from the 9 program councils per year. 5 forums have been completed in the first quarter which would point to us achieving that goal.
The other 4 standards are being reported at a corporate compliance rate of over 86%. (Badges 86%, whiteboards 90%, Communication 89%, hourly rounding 86%) For those areas not meeting the goal directors and managers look to find ways of supporting staff and physicians to increase their compliance.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

There are no obvious barriers to us maintaining this performance and meeting the year-end target.

Definition: DATA: D. Bell COMMENTS: D. Bell STRATEGY REPORT

With the implementation of the Interprofessional Collaborative Practice Model (ICPM), specific practices have been introduced to support patient- and family-centered 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
- Communication (introduction and statement of role)
- Purposeful 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 14/15: 100% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%

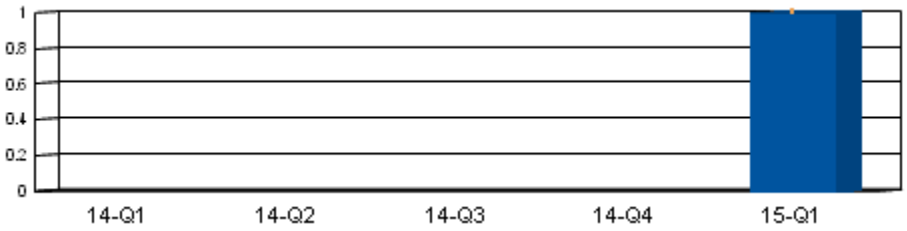
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

Cultivate patient oriented research

Externally funded research at KGH has increased by 50%

Indicator: Research Joint Venture Project Implementation Plan Is Meeting All Quarterly Milestones



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Issue and RFP and commence creation of a constitution, structure, governance and business plan: RFP drafted and out to tender for joint venture. Receipt of only one proposal from vendors for creating joint venture.

Develop a KGH Research Institute website with potential use for the joint venture: Vendor contract negotiations completed for KGH's web renewal project (includes KGHRI website). Hired an external service provider (communications consultant) to assist with KGHRI website and KGHRI branding. Rolled-out research report (first 3 years). Finished filming researchers and compiling stock photography of research groups/areas. Reviewed current research website internally for content audit and future information architecture in preparation for meeting next quarter with vender.

Launch development of the Centre for Patient-Oriented Research: CFI grants awarded to GIDRU and Neurosciences: ~$1.2 million to be used towards Connell 4 project. RFP for Functional Programmer completed and vender selected (HDR Architects). Functional Programmer met with research stakeholders to discuss requirements for functional & space programs. Functional Programmer completed functional & space programs. UHKF has raised in pledges and past donations ~$2 million for project.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Based on the fiscal year to date, KGH is on target by the end of the first quarter. A RFP was issued for the purpose of obtaining proposals to support the academic partners (Queen's, KGH, HDH, and PC) in creating a constitution and operational plan for a new a partnership or joint venture to be established with the intent of enhancing the coordination, visibility, promotion and growth of health research, collectively and at their individual institutions. By not enhancing the coordination, visibility, promotion and growth of health research, we will run the risk of not being competitive in recruiting high quality personnel and researchers.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

We are on track to meet our target by year end.

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

A RFP is being issued for the purpose of obtaining proposals to support the academic partners in creating a constitution and operational plan for a new a partnership or joint venture to be established with the intent of enhancing the coordination, visibility, promotion and growth of health research, collectively and at their individual institutions. The scope of this new venture will include all current and future research carried out in the physical facilities of the academic partners, or off-site, led by Queen's faculty with primary appointments in the Faculty of Health Sciences or researchers at any of the three hospital research institutes. Currently, research revenues of the academic partners are approximately $85 million per annum.

Target: Target 14/15:As per stated project milestones Perf. Corriodors: Red No Yellow N/A Green Yes

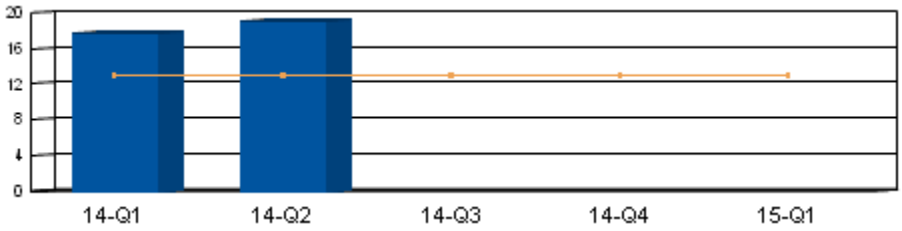
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

Increase our focus on complex-acute and specialty care

KGH services are well aligned and integrated with the broader health care system

Indicator: Readmission Rate within 30 Days for Selected CMG's to Any Facility (QIP)



	Actual	Target
14-Q1	17.80	**12.9**
14-Q2	19.04	**12.9**
14-Q3		**12.9**
14-Q4		**12.9**
15-Q1		**12.9**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

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. There are three tactics planned for fiscal 14/15. They are as follows: Improve discharge summaries sent within 72 hours, participate in health links, conduct a value stream on map on readmissions.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The data is supplied to KGH from the MOH and generally will be 3 quarters behind. The current rate of 19.04 is above the target of 12.9 and weakened to Red status. Readmission rates remain a focus for fiscal 14/15 with a complete VSM exercise planned for Q1 fiscal 14/15.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

It is uncertain at his time where the target will be met.

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

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%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%

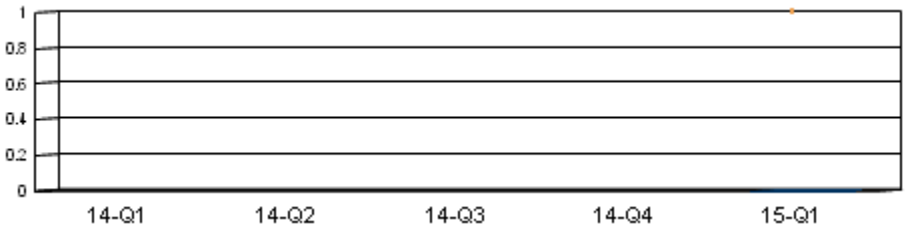
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

People

Staff are engaged in all aspects of our quality, safety, and service improvement intiatives

Indicator: Quarterly Engagement Plan Status



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

There were 4 of areas of focus identified through the NRCC survey process as recommended areas to develop corporate initiatives. Corporate initiatives related to trust, recognition, education and career development and health and wellness were chosen. The corporate plan was approved and follow-up was conducted with Directors at the end of Q1 related to engagement action plans in their portfolios. Leaders Performance Agreements for 2014/2015 were adapted to ensure a report on the leader's team engagement action plan.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Continue to seek feedback and define specific area representing trust to build on. Respect was selected; however the action plan was not finalized in Q1 as per the corporate engagement plan. The development of the corporate learning and education approach is ongoing, but not yet completed. Frontline leadership course pilot conducted. A review of the plan to conduct a psychological risk assessment was undertaken. Touch point mini surveys will be conducted in targeted areas to assess progress; and the learning and development strategy will be solidified. Volunteer orientation improvements are expected to also roll out. Physician results continued to be shared with departments and involvement in decision making is ongoing. Volunteer results were shared.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are on track to hit target; with the hire in June of the Lead for Leadership and Learning, all elements of the corporate plan will be met for Q2.

Definition: DATA: Micki Mulima COMMENTOR: Micki Mulima STRATEGY REPORT

There is a strong relationship between Engagement and organizational performance.
There were a number of areas of focus identified in the engagement survey results that will be looked at including the 4 overall corporate initiatives related to trust, recognition, education and career development and health and wellness. Physician survey results will continue to be used to develop strategy and plans. The top two areas of focus from the Volunteer engagement survey results will be acted upon.

Target: Target 14/15: As per plan quarterly milestones

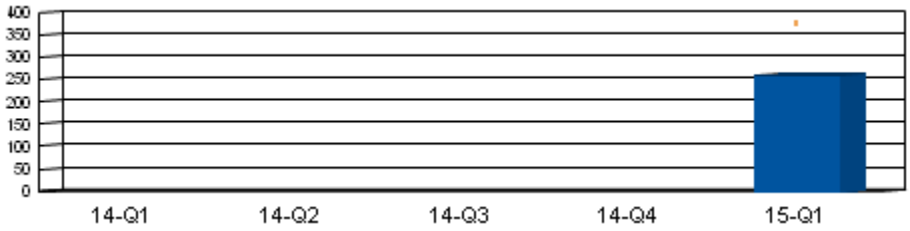
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

People

Staff are engaged in all aspects of our quality, safety, and service improvement intiatives

Indicator: Number of Staff with Performance Reviews and Agreements on File



	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	259	**375**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Having performance conversations aligns with engagement, enables high performance and reinforces individual accountability. Several departments with front line staff introduced the performance conversation and it is expected Q2 will demonstrate further progress on completion as a result. Open information sessions are scheduled and advertised for staff. There has been follow up with leaders to target their areas, provide tools and supports and develop a plan for meeting the target will continue.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

There was targeted focus on the non-union group to complete the review of 2013/2014 Performance Agreements for the KGH Leadership Group, and Goals and Development Agreements for the other non-union personnel. There continued the pilot of union performance and goals process, assessment and communication. There was the development of a tracking mechanism, user guides and information sessions which rolled out in targeted departments.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are on track to meet the target by the end of the fiscal year.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima STRATEGY REPORT

Performance reviews and agreements are one piece of the performance management process. By encouraging a continuous dialogue between management and staff it enables managers to evaluate individual performance and enhance productivity and engagement. Benefits include aligning employee's tasks to the overall strategic goals of the organization, providing accountability, and better documentation to support compensation.

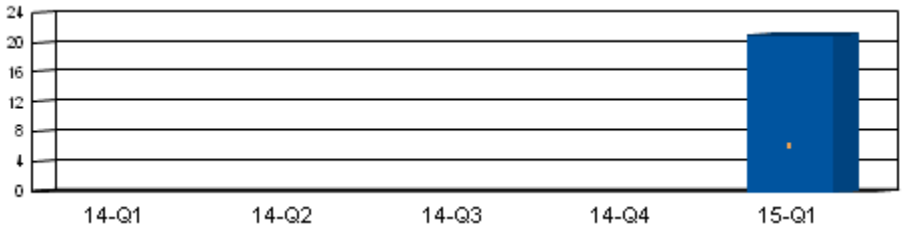
Target: Target 14/15; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375

Strategy Performance Report Fiscal 2015 Q1

People

All preventable harm to staff is eliminated

Indicator: Number of WSIB Health Care and Lost Time Injury Claims due to MSI



	Actual	Target
14-Q1		
14-Q2		
14-Q3		
14-Q4		
15-Q1	21	**6**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Memo for information and action on Q1patient-handling related MSIs sent to Program Managers and Directors July 17, 2014. Meetings with Medicine and SPA Programs planned to review injury data and opportunities for prevention including available Ergonomist support for hands-on staff training for units with high incidence. Q1 increases in these patient-handling MSIs to be shared with Move-On teams to ensure safe practices for staff are integrated into the roll out of Move-On. Ergonomist to meet with Move-On champions as well.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Nearly 70% of our MSI-related health care claims (n= 14 out of 21) occurred during patient-handling activities (during transfer, repositioning, lifting) with 13 resulting in healthcare and 1 in a lost time injury claim. Highest incidence of WSIB claims resulting from MSIs occurred in SPA (7), Medicine (4), and the ER (2);

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

No. It is highly unlikely that the target will be met. Safe Patient Handling LMS training to be rolled out in Q2.

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan STRATEGY REPORT

As the most prevalent type of injury in the healthcare sector and at KGH, musculoskeletal injuries (MSIs) result in significant costs and can result in delayed recovery and permanent impairment for workers. MSIs that require workers to seek healthcare treatment or result in lost time from work, trigger a WSIB reportable injury claim and are a measure of incident severity.

Target: Target 14/15: 6 Perf. Corridors: Red >7 Yellow 7 Green <=6

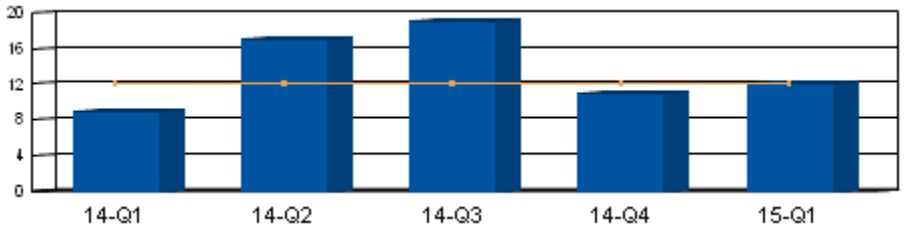
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

People

All preventable harm to staff is eliminated

Indicator: Number of Needlestick Injuries



	Actual	Target
14-Q1	9	**12**
14-Q2	17	**12**
14-Q3	19	**12**
14-Q4	11	**12**
15-Q1	12	**12**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Plan is to work with OR to determine if opportunities for implementation of alternate (blunt) suture needles for certain uses. Needle Safety Training to be rolled out via the LMS in Q2. Business case for conversion from insulin needles to insulin pens has been approved and is expected to result in reduced NSIs.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Over 50% of the injuries occurred in the SPA program (n= 7). Suture needles were involved in 33% of the incidents

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are on track to meet the target by year end.

Definition: DATA: Joanna Noonan COMMENTS: Joanna Noonan

Total number of needlestick injuries reported by workers in the Safe Reporting Tool; does not include other non-needle sharps-related injuries.

Needlestick injuries (NSIs) are one of the indicators used to measure the success of KGH's sharps management program. NSI incidence is also used by the Ministry of Labor to determine whether the hospital is putting in place adequate controls to protect workers from the risk of blood-borne pathogens. Each year thousands of health care workers sustain needlestick injuries in Canada; each one of these injuries carries the risk of exposure to serious and even potentially fatal infections with blood borne pathogens such as Hepatitis B and C, and HIV. Analysis of needlestick injury data, investigation of all needlestick injuries, and implementation of corrective measures/improvements

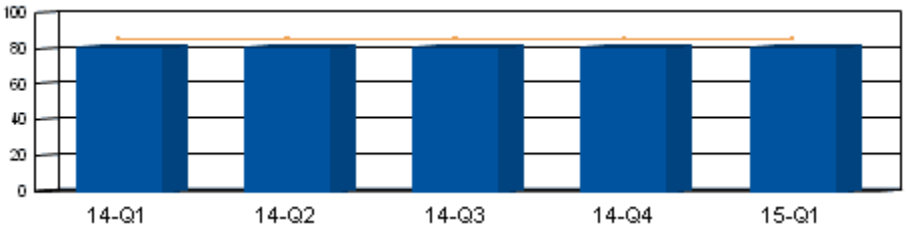
Target: Target 14/15: <=48(12/qtr.) Perf. Corridor: Red >=15 Yellow 13-14 Green<=12

Strategy Performance Report Fiscal 2015 Q1

Facilities

Phase 2 construction is under way and KGH is clean, green, and carpet free

Indicator: Percent Compliance with Cleaning Audits



	Actual	Target
14-Q1	81	**85**
14-Q2	81	**85**
14-Q3	81	**85**
14-Q4	81	**85**
15-Q1	81	**85**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

This indicator is a result of independent cleaning audits by the third party company Westech. These external audits are performed semi-annually. Environmental Services Management are certified and utilize the same tools as the Westech Auditors to conduct monthly internal audits and follow-up with staff in areas that did not receive a minimum of a 85% target. The July internal audits were 84.02%. Redesigns of services have created two specific teams; one to focus on cleaning upon a patient discharge and the other to provide the daily cleaning functions. These changes are designed to improve cleaning quality.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The most current results are from March 2014 external audit report with a score of 81%. A statistically representative sample size (259 rooms) of all the rooms in the different departments in four risk categories were audited. The overall score for a room is based on up to 19 inspection elements that have different weights. The March independent audit score of 81% which is below the Industry Standard of 85%.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes, we are on track to achieve our 85% target.

Definition: DATA: Jim Jeroy COMMENTS: Jim Jeroy STRATEGY REPORT

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.

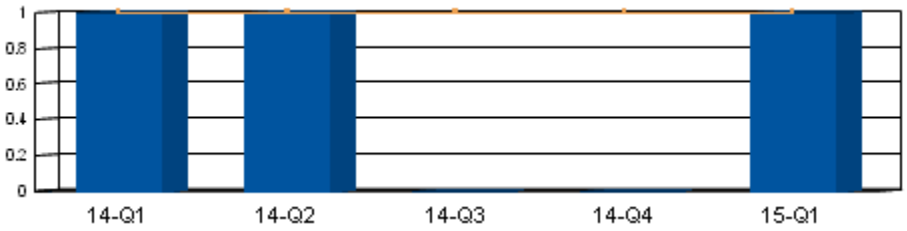
Target: Target 2012/13: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%,Target 2014/15: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

Strategy Performance Report Fiscal 2015 Q1

Facilities

Phase 2 construction is under way and KGH is clean, green, and carpet free

Indicator: Stage 2 Approval Status



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

The Ministry has a well-defined process for Capital Projects and KGH is current in Stage 1 and our goal is to obtain Stage 2 approval in F2015. In order to satisfy MoHLTC questions related to Stage 1, the submission of a Surgical Plan encompassing both KGH and HDH was requested. A Surgical Plan was completed in Q1, approved by both KGH and HDH, and submission to the Ministry of Health and Long Term Care (MoHLTC) and the LHIN was made in May 2014.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

On 11 July 2014 South East LHIN formally notified MOHLTC of its support for the KGH/HDH Surgical Plan addressing MOHLTC questions in regards to the KGH Stage 1 submission. We have been following up with MoHLTC from each of the KGH Planning Office, and Chief Operating Officer and President (CEO) offices, but as of August 29 the file remains under Capital Branch review.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Uncertain, KGH is continuing to follow up with LHIN and MoHLTC and offering to provide any required support to obtain approval for Stage 2. We are also working with our partners to engage the new Senior Ministry officials and educate them on our project request and needs (including visits). Complicating the process is the understanding that the MoHLTC has indicated they are now reviewing their existing capital processes for prioritization and selection of projects.

Definition: DATA: Allan McLuskie COMMENTS: Allan McLuskie STRATEGY REPORT

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.

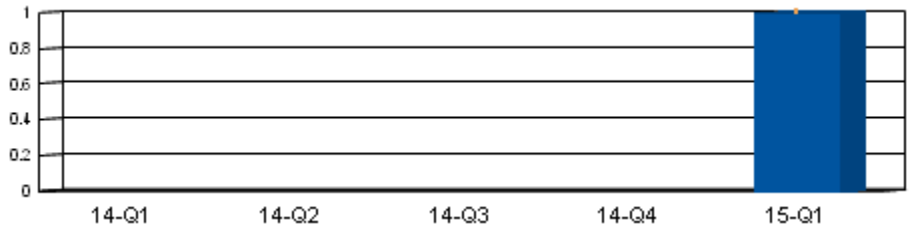
Target: Target 13/14 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes,Target 14/15 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes

Strategy Performance Report Fiscal 2015 Q1

Technology

Rapid transmission of information improves care and operational efficiency

Indicator: Regional Health Information System Planning Process is Meeting all Quarterly Milestones



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

Describe the tactics that were implemented in this quarter to address the achievement of the target:

HIS RFP Kick Off took place in Q1 and we reached regional consensus on the clinical requirements. All non-clinical and technical requirements have been collected ahead of schedule. Regional timelines for the RFP development have been drafted and are awaiting approval by the SE LHIN I.T Executive Committee.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

Technical requirements gathering will aid in the creation of a regional RFP whereby all seven (7) SE LHIN hospitals can make a decision on purchasing a new Health Information System (HIS). Currently this performance target is on track with the consultants anticipating that the RFP will be assembled and ready by Q3.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Yes. Plans for next quarter are to reach regional consensus on the non-clinical / technical streams and complete 'Horizontal' sessions in order to collect workflow information related to the patients' journey (e.g. entry to the program, department to transfer, discharge).

Definition: DATA: Dino Loricchio COMMENTS: Dino Loricchio STRATEGY REPORT

Target: Target 14/15: As per implementation schedule

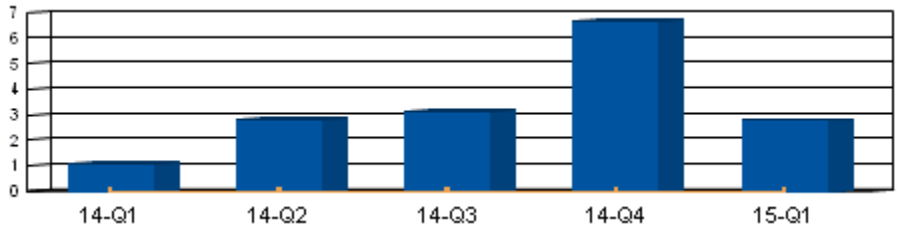
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

Finances

Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures

Indicator: Total Margin (QIP)



	Actual	Target
14-Q1	1.08	**0**
14-Q2	2.78	**0**
14-Q3	3.09	**0**
14-Q4	6.67	**0**
15-Q1	2.77	**0**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Monthly financial reporting and analysis support were provided to those with budget responsibility. High-level summary results by category were also provided to the KGH senior leadership team for review.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The total margin as at June 30th, 2014 was 2.77%.This result is within the Ministry acceptable range (0 - 3%).

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

The total fiscal results were unfavorable to plan at the end of the first quarter. As such, those areas more than 5% offside and totaling more than $100 thousand were requested to complete an evaluation and undertake early interventions to facilitate the necessary corrective action required to bring results in line with the total year budget plan. Monitoring activities will continue.

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

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, Target 14/15: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

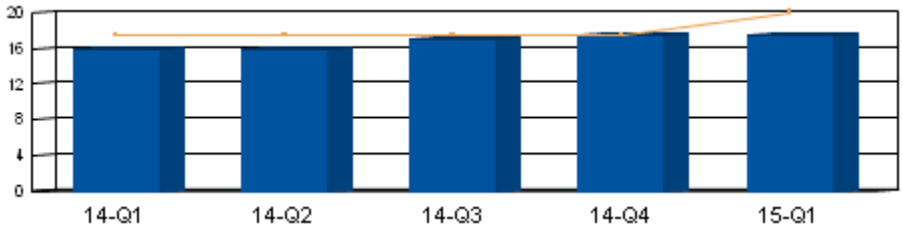
Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

Finances

Our operating budget is balanced and we are able to allocate $20 million a year to capital expenditures

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



	Actual	Target
14-Q1	16	**18**
14-Q2	16	**18**
14-Q3	17	**18**
14-Q4	18	**18**
15-Q1	18	**20**

Describe the tactics that were implemented in this quarter to address the achievement of the target:

Identified operational efficiencies were included in the operating budget to provide capacity for investment in capital.

Explain the current performance of the target. Where possible, translate statistics and numbers into plain language, focusing on the impact to patients and staff:

The capital investment capacity currently totals $17.5 million. This investment will be utilized to support the replacement/upgrade of building infrastructure, technology and clinical and non-clinical equipment.

Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

At this point in time it is not anticipated that the investment capacity will meet the $20 million target set for fiscal 2015. Hospital senior leadership are engaged to review additional operational efficiencies identified in prior years that may provide further capacity for capital spending.

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

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

Kingston General Hospital

Strategy Performance Report Fiscal 2015 Q1

Status:

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