fiscal 2014-2015 **Q3**

3rd quarter ended December 31, 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

Q3 FY2015 Strategy Performance Indicators Report

Strategic Direction	2015 Outcome	Indicator	14-Q3	14-Q4	15-Q1	15-Q2	15-Q3	
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)	G	Y	G	R	R	↑
		Hand Hygiene Compliance - (QIP)	R	R	R	R	R	↑
		Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)	N/A	N/A	G	R	R	↓
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	G	G	N/A	N/A	N/A	↑
		Medication Reconciliation at Admission (QIP)	R	R	R	R	R	↑
		Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)	R	R	Y	Y	R	↓
		Number of Incidents Associated with Morphine or Hydromorphone	N/A	N/A	R	G	Y	↑
		Number of Specimen Collection and Labelling Errors	N/A	N/A	R	R	R	↑
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	G	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	R	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	Y	R	R	R	R	↓
		Overall Medical/surgical Occupancy Rate (Midnight Census)	N/A	N/A	Y	R	R	↓
		OR Cancellation Rate	G	G	Y	Y	Y	↓

Strategic Direction	2015 Outcome	Indicator	14-Q3	14-Q4	15-Q1	15-Q2	15-Q3	
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	G	G	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	G	G	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	Y	N/A	N/A	N/A	↓
People	Staff are engaged in all aspects of our quality, safety, and service improvement intiatives	Quarterly Engagement Plan Status	N/A	N/A	Y	G	Y	↑
		Number of Staff with Performance Reviews and Agreements on File	N/A	N/A	Y	R	G	↑
	All preventable harm to staff is eliminated	Number of WSIB Health Care and Lost Time Injury Claims due to MSI	N/A	N/A	R	R	R	↑
		Number of Needlestick Injuries	R	G	G	R	R	↓
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	R	R	Y	Y	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	G	G	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	G	Y	G	G	↑

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

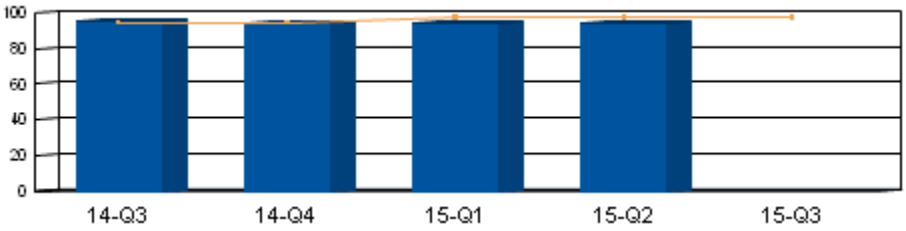
	Strategy				QIP				Supporting			
	Q1 %	Q2 %	Q3 %	Q3 #	Q1 %	Q2 %	Q3 %	Q3 #	Q1 %	Q2 %	Q3 %	Q3 #
R	33%	52%	44%	12	42%	67%	42%	5	28%	33%	34%	28
G Y	67%	48%	56%	15	58%	33%	58%	7	65%	66%	66%	55
N/A	0%	0%	0%	0	0%	0%	0%	0	7%	1%	0%	0
				27				12				83

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	95.0	**94**
14-Q4	93.8	**94**
15-Q1	94.0	**97**
15-Q2	94.0	**97**
15-Q3		**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 questions 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:

As of November 20th, 2014, 560 staff, learners and volunteers have completed the Communicate with HEART training. As we had exceeded the tactic target of 500 being trained, the course was put on hiatus three weeks earlier than scheduled to allow resources to focus on other priorities. The plan all along was to review the training course during the hiatus through a PDSA process. This has been completed and training is scheduled to resume February 10th, 2015.

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. The Q2 data is the most recent.

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.

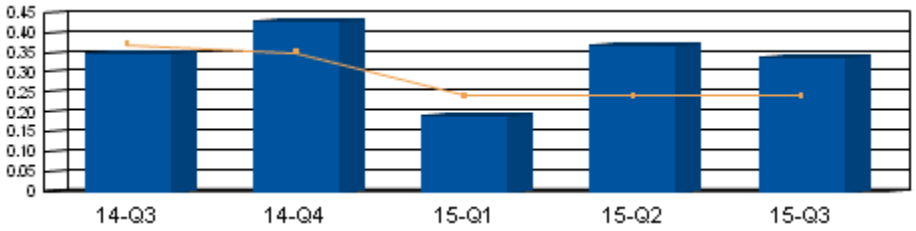
Target: Target 12/13: PTAOB, Target 13/14: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%,Target 14/15: PTAOB Perf. Corridor: Red <=80% Yellow 80%-89% Green >=90%

Q3 FY2015 Strategy Performance Indicators Report

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

All preventable harm to patients is eliminated

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



	Actual	Target
14-Q3	0.35	**0.37**
14-Q4	0.43	**0.35**
15-Q1	0.19	**0.24**
15-Q2	0.37	**0.24**
15-Q3	0.34	**0.24**

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

Efforts to manage small clusters of cases, which are becoming uncommon include: added environmental cleaning, education of staff, increased clinical vigilance with institution of pre-printed orders, presence and support from IPAC and ASP.

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 CDI rate for this quarter was 0.34 cases per 1000 patient days; a slight decrease from Q2, however we are still above our target rate of 0.24. These rates represent 13 cases in this quarter, one less than last quarter. There was a small cluster on one of the units in October and another two cases on the same unit in November but there have been no cases of CDI on this unit since that time. December 2014 marks 30 months with no declared CDI outbreaks at 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?

We are on track to meet target.

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

Q3 FY2015 Strategy Performance Indicators Report

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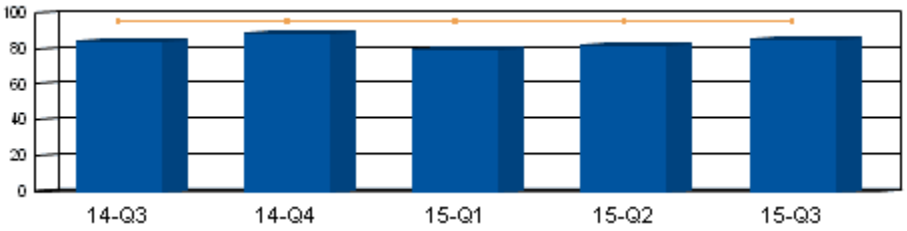
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
14-Q3	83.7	**95**
14-Q4	88.2	**95**
15-Q1	79.7	**95**
15-Q2	82.0	**95**
15-Q3	85.0	**95**

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

Patient Perspective: Our before moment is 85%, our after moment is 90% for an overall corporate HH rate of 88%. These rates are the reflection of 5,016 observed opportunities.

Business Perspective: Last year for Quarter 3, our before moment was 80%; our after moment was 90% and we had an overall corporate HH rate of 84%. We had 2, 846 observed opportunities.

The corporate HH Working Group has been meeting and a review of current model has been conducted with challenges and sustainability concerns identified. A new model is being developed with a goal to incorporating "Just in Time" interventional training to the auditors role.

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 hand hygiene compliance rate for the before contact with the patient/patient environment moment. Hand hygiene is reported annually at the end of Quarter 4 in April. All four moments are reported to the Ministry, however only moment one and moment four are posted for the public.

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 unlikely that will meet the target of 95% this year. Significant efforts within programs this year have resulted in an increase in the number of observed opportunities increasing the denominator throughout Quarter 2 and again in Quarter 3. Hand Hygiene compliance rates are trending in the right direction however we are still well below the target for the "before" moment.

The Hand Hygiene Working Groups has identified new improvements that will contribute to further improving compliance rates and optimize patient's safety by reducing opportunities for the transmission of organisms via healthcare workers hands. New initiatives will target education on the appropriate usage of gloves and enhance the understanding of hospital environment and patient environment parameters.

Definition: DATA: Infection Control 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%

Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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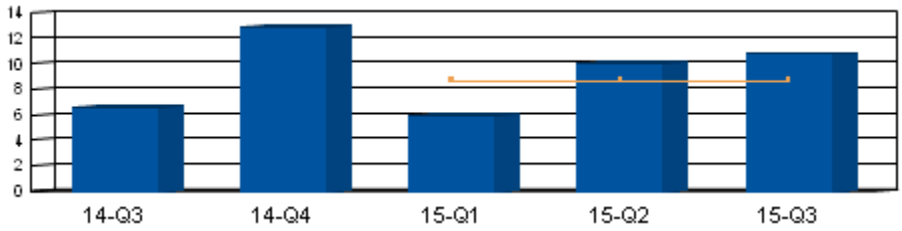
Indicator: Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)



	Actual	Target
14-Q3	6.60	
14-Q4	12.90	
15-Q1	5.90	**8.68**
15-Q2	10.07	**8.68**
15-Q3	10.74	**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 by Clinical Departments similar to the standard mortality process. The mortality reviews are discussed at JQUIC and MAC.

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 Q3 rate is greater than the provincial target. Mortality reviews have not found issues/concerns with care or process. There were 9 deaths in 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?

No

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

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

· Unit of analysis: The measuring unit of this indicator is a single admission. The indicator is expressed as a rate of in-hospital deaths within five days of major surgery per 1,000 major surgical cases.
· Denominator: Hospitalizations with major surgery performed between April 1 and March 25 of the fiscal year.
· Numerator: Cases within the denominator where an in-hospital death occurred within five days of major surgery.

Target: Target 14/15: 8.68 Perf. Corridors: Red >=9.55 Yellow 8.69-9.54 Green <=8.68

Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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

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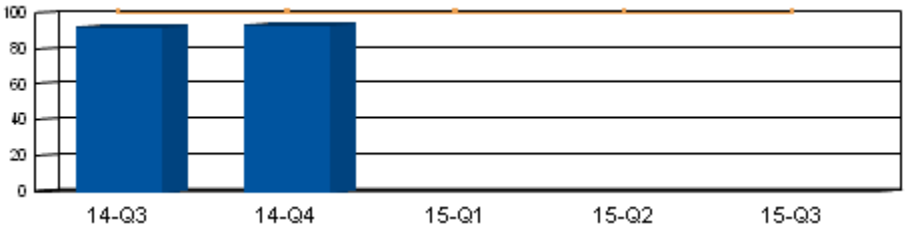
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



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

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

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

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

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

Q3 FY2015 Strategy Performance Indicators Report

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

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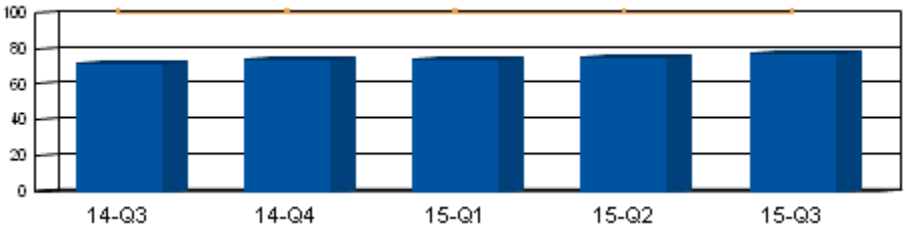
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
14-Q3	72	**100**
14-Q4	74	**100**
15-Q1	74	**100**
15-Q2	75	**100**
15-Q3	77	**100**

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

A standard Surgery Admission Order Set embedding the medication reconciliation process endorsed by the Executive Committee of the Division of Surgery and the Surgical Program Council has been submitted to the Order Set Committee for approval with plan to implement in February 2015.

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 the time of admission to the Hospital has increased from 75% in F15 Q2 to 77% in F15 Q3, a slow but steady and constant increase since implementation of this indicator in F14 Q1.

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 Hospital is on track to improve the target by end of Fiscal year. Target should be met in Q1 of F16. With the implementation of the surgery admission order set in February 2015, the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital should exceed 80% by F15 Q4 and reach 90% in F16 Q1.

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%

Q3 FY2015 Strategy Performance Indicators Report

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

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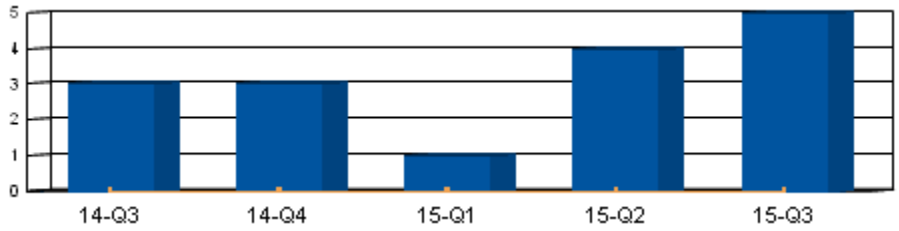
Indicator: Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)



	Actual	Target
14-Q3	3	**0**
14-Q4	3	**0**
15-Q1	1	**0**
15-Q2	4	**0**
15-Q3	5	**0**

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

All patient falls present a risk of injury. Hospitalization increases risk of falls due to an unfamiliar environment, illness, and reduced mobilization 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. Units who received the education were to establish improvement teams to support increased consistency of use of the Falling Star Program and identify improvement cycles to support safe mobilization of patients. All this work was to be completed by end of Q2. Q3 was planned to support 'sustainability' of the Falling Star and Mobilization improvements for each unit. Q4 is to be used to identify the next step of improvement cycles.

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

Four level 3 falls have been experienced in the third quarter & one level 4 [of the 5 falls reported 3 occurred within the Oncology Program & 2 within the Medicine Program]; all have been reviewed for actual severity level and to identify causal factors that can be used to support improvements. All 5 falls involved ambulating patients. Patients were identified to have appropriate levels of supports in place. There were no specific gaps in the safeguards expected.

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 not on track to deliver zero level 3 or 4 falls within the fiscal year. The improvement cycles though are on track. We will develop further improvements and identify other risk factors to address as per the plan for Q4. Examples of further improvement opportunities include having the right equipment (e.g. high low beds), general environmental issues (e.g. remove ridges in shower stalls), and medication management.

Definition: DATA: Decision Support COMMENTS: Richard Jewitt 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 >6 Yellow 4-6 Green <4

Q3 FY2015 Strategy Performance Indicators Report

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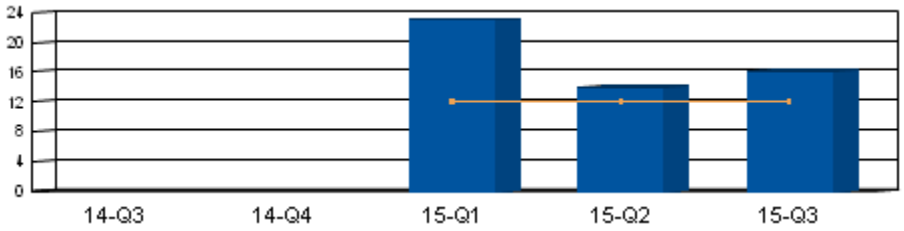
Indicator: Number of Incidents Associated with Morphine or Hydromorphone



	Actual	Target
14-Q3		
14-Q4		
15-Q1	23	**12**
15-Q2	14	**12**
15-Q3	16	**12**

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

In October 2014, the Medication Safety Committee and the Nursing Practice Council approved the implementation of a safeguard for the medication HYDROmorphone.The safeguard is an automated double checks with warning: “ALERT – you are accessing hydromorphone (Dilaudid®)” programmed in the Automated Dispensing Cabinets (ADCs) to display each time HYDROmorphone is removed from the ADC with an override.

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 50% reduction in the incidence of hydromorphone and morphine medication administration incidents through the implementation of ADCs was not achieved in F15 Q3. Sixteen reported medication administration incidents associated with morphine or HYDROmorphone is above the target of 12 for this quarter. None of the incidents were reported as level 3 (moderate harm) or level 4 (serious/critical incidents). Out of the 16 reported administration incidents, six involved morphine and 10 involved hydromorphone. Of note, there were no incidents involving hydromorphone being given when morphine was ordered since the new safeguard was implemented. However, two incidents involved giving morphine when hydromorphone was ordered this quarter (none reported in Q1 and Q2). Administration incidents continue to include incorrect dose/strength, incorrect frequency, incorrect medication, incorrect formulation, and incorrect route.

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 Hospital will not meet target by end of Fiscal year. A Morphine & Hydromorphone Nursing Education program for both RNs and RPNs endorsed by Program Operational Directors, the Nursing Practice Council, and the Medication Safety Committee will be implemented in F15 Q4.
A mandatory e-learning module via LMS is being developed with plan to implement in March 2015.

Definition: DATA:Veronique Briggs COMMENTS: Veronique 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

Q3 FY2015 Strategy Performance Indicators Report

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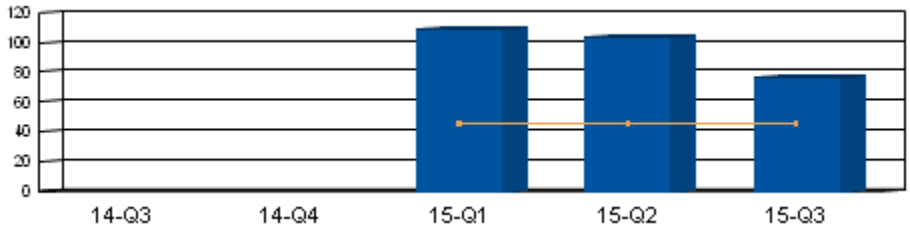
Indicator: Number of Specimen Collection and Labelling Errors



	Actual	Target
14-Q3		
14-Q4		
15-Q1	109	**45**
15-Q2	104	**45**
15-Q3	76	**45**

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

The indicator continues to move in the right direction. Many tactics are in place to further reduce the overall specimen collection errors. The phlebotomy team has contributed to the overall reduction of specimen collection and as of January 2015 has been rolled out hospital. The Pre Analytical Manager is working closely with the units reviewing SAFE reporting incidents to help identify educational or process changes required to improve specimen quality. A value stream map has been done in Davies 4 and Kidd 2 ICU so from that opportunities will be defined for process improvements and standardization.

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 principles around specimen collection do not change. Through all the work that has been done around reducing specimen collection errors, the complexity, the high degree of integration of various health professionals influence the final result.

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 target set for this particular indicator is both aggressive and bold. The hard work done to date is trending in the right direction. Not all areas of the hospital use Lab Order Entry as originally planned. Work is now focusing on those areas and once this is completed will result in a further decrease in the number of unlabeled/mislabeled specimens. The clinical laboratory working closely with the various stakeholders has raised the level of specimen quality throughout the organization and this directly impacts patients.
In the processes that are not influenced by the presence of a phlebotomist i.e. Fluid samples, mircobiology samples, histo/pathology samples collected in the Operating Room there is an opportunity to enhance standardized processes in those pre analytical phases in those patient care settings.

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

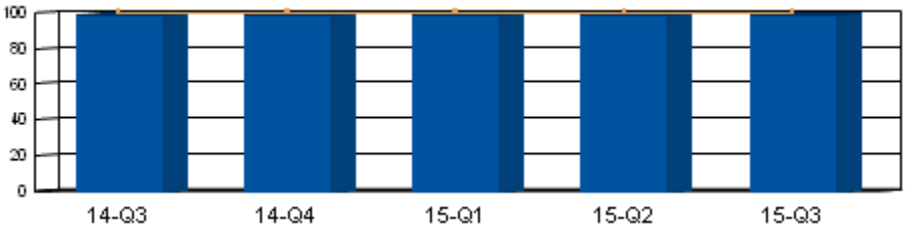
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	99	**100**
14-Q4	99	**100**
15-Q1	99	**100**
15-Q2	99	**100**
15-Q3	99	**100**

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

The monthly review of the Surgical Safety Checklist metrics by the Program council and at OR staff meetings have assisted in the sustainability of meeting this target.

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 Q3, this indicator continues to meet the green target corridor. There were 2,249 patients who received surgery in this quarter. The OR team's compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.4 %, Timeout-99.2%, and Debrief- 99%. The unscheduled/emergent cases and consistent compliance to the surgical safety checklist completion continues to be an area of focus for the next quarter.

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 continues to be on track to meet this target.

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.

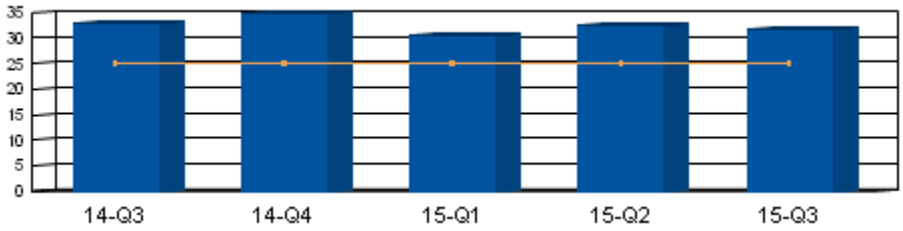
Target: Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	33.0	**25**
14-Q4	35.0	**25**
15-Q1	30.7	**25**
15-Q2	32.6	**25**
15-Q3	31.6	**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. The Patient Flow Task Force, which has representation from across all programs and services as well as CCAC and Providence Care, has oversight of these initiatives and receives updates twice a month and is in the process of evaluating all the rapid improvement cycles done to date. The task force will refocus efforts as directed by the results of the evaluation. The new bed map will take effect on January 26 and it is anticipated that the realignment of beds will have a positive impact on this indicator.

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 Q3 result of 31.6 hours is 7 hours longer than the 25 hour target. Ninety percent of all patients admitted through the ED waited up to 31.6 hours to be transferred to an inpatient bed. Ten percent waited longer than this. Based on Q3 admission volumes of 2737, 273 patients waited longer than 31.6 hours in the ED for an inpatient bed. Inpatient days in the ED are 958 this quarter 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. LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning. Our actual performance is not significantly different from our peers given the range in performance throughout the year. LHSC = 32.3, HHSC = 26.2, SMH = 21.3, SHSC = 26.8, TOH = 30.1, TBRHC = 31.6, Sudbury = 29.9
The LHIN target is not a reasonable target and the SE LHIN has acknowledged it needs to be revisited for 15/16.

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. However, with the re-commission of Inpatient beds with the new bed map, it is expected to help minimize the delays in transferring patients to inpatient beds with the potential of improving on 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

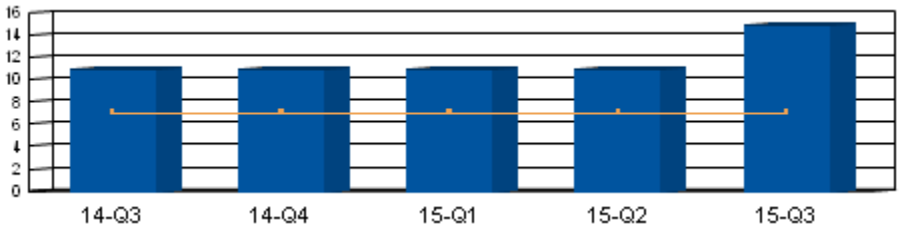
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	11.0	**7**
14-Q4	11.0	**7**
15-Q1	11.0	**7**
15-Q2	11.0	**7**
15-Q3	14.8	**7**

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

KGH and regional partners have committed to a renewed focus on ALC and as a result, a number of initiatives are underway.
Within KGH, steps that are being taken include:
A registered nurse has been seconded to be the KGH point of contact for ALC patients.
A 'tiger team' has been meeting weekly since November 3rd to look at the current status of ALC patients at KGH, to review & revise any processes and to advise on steps to support consistent adoption of ALC designation processes.
A review of patients designated ALC is underway to determine specific profiles that emerge and that could be used to support care or different models of care in the community.
The ALC designation process is being refreshed to include the development of a message that supports exploring all options for transition of care or discharge.
KGH is leading a weekly regional huddle with LHIN partners to review & discuss the patient flow profile across the region.

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 patients' 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 Q3 result of 14.8% indicates that, on average, there were more than 60 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.
The regional weekly patient flow huddle generates a regional snapshot of key ALC and patient flow indicators with the aim to mobilize opportunities to facilitate patient flow between organizations. All partners are experiencing the same issues. Data from the last huddle indicates there are 173 ALC patients in the SE LHIN and these patients occupy between 11 and 50% of budgeted beds (KGH ALC patients occupied 13% of budgeted beds during this time period).

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 unlikely that will meet the target of 7% this year. Despite significant efforts across hospitals and the SE CCAC, ALC rates have been escalating over the past 5 months. In August 2014, there were 40 ALC patients at KGH and by the end of November, there were 70 ALC patients. The set target is 22 ALC patients. KGH has remained in Gridlock since October 28th.
The continued rise in the numbers of patients designated as ALC is of great concern. The team is discussing options to optimize care of patients with chronic or complex conditions through Health Links and reduce avoidable hospital admission from long term care homes or retirement homes. KGH staff members are participating in a LHIN-based peer to peer patient flow task team to develop policies and processes that will be implemented across all SE LHIN organizations.
The CCAC coordinators' labour disruption that began on January 30, 2015 has a potential to impact our percent ALC days in Q4.

Definition: DATA: Decision Support COMMENTS: Cynthia Phillips 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%

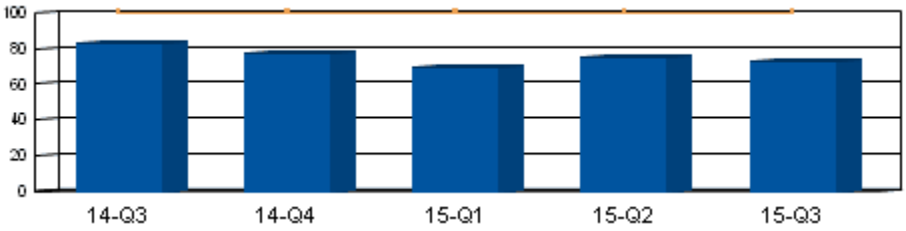
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	83	**100**
14-Q4	77	**100**
15-Q1	69	**100**
15-Q2	75	**100**
15-Q3	73	**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. Updated metrics and QBP performance dashboards have been introduced and are widely circulated and reviewed.

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 (by 1) in the number of services meeting the 90th percentile wait time target in Q3. 14 of 52 clinical areas have a status of Red with respect to meeting their wait time targets: 2 general surgeries; 1 gyn, 2 neurosurgery, 1 dental oral surgery; 3 orthopedic; 2 plastics, 2 urology, and 1 DI (MRI). Note: The dental oral surgery is exclusively at HDH. 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?

No. It is unlikely that all 52 areas clinical areas will meet their targets by yearend. Challenges with access to acute care beds as a result of high ALC numbers and frequent gridlocks will prevent these targets from being met. It is worth noting that there is an education initiative underway with surgical offices that is aimed and improving the accuracy of the priority score assignment.

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%

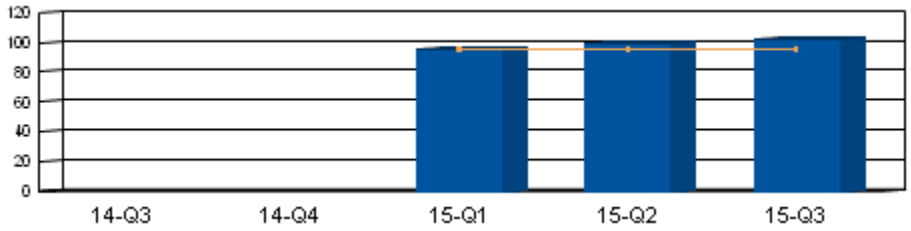
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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: Overall Medical/surgical Occupancy Rate (Midnight Census)



	Actual	Target
14-Q3		
14-Q4		
15-Q1	96	**95**
15-Q2	100	**95**
15-Q3	102	**95**

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

Occupancy/utilization and ALC data is reported to programs and at a corporate level for awareness, and is shared with the LHIN during quarterly reviews in light of system influences and impacts. Recognizing the importance of timely access to KGH's beds to meet acute care needs in the region, much attention is being placed on achieving a 95% occupancy target. Considerable effort has been made to reduce length of stay however; the growing number of ALC patients occupying acute care beds along with increase in the number of admissions from Emergency are adding pressure for bed access and driving up the occupancy rate. Bed map redesign will be fully implemented in Feb 2015, bringing 14 temporary beds on Connell 3 on line with permanent status. An ALC Task Team was formed in Q3 and was given a mandate to focus on appropriate ALC designation and facilitating discharge. Early results from this team are showing positive results in lowering the ALC number at KGH. The hospital remains transparent with regional partners and the LHIN on ALC and Gridlock status. In early December 2014, a weekly regional huddle was established that brings together hospitals, CCAC and the LHIN to generate and discuss a regional snapshot of key ALC and patient flow indicators with the aim to mobilize opportunities to facilitate patient flow between our organizations as needed. ALC is identified as a SECHEF priority and will be integrated into future system design through the Health Care Tomorrow initiative. KGH is working with their teams and our partners on the initiatives related to behavioral support in community as well as ALC flow.

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 Q3 overall medical/surgical occupancy rate of 102% exceeds the target of 95%, 2% higher than the rate in Q2. Occupancy at this rate reflects the challenge with having capacity to support patient access to beds and patient flow. As indicated in Q2, in spite of initiatives that are directed to and having a positive impact on length of stay, a number of factors are driving the 102% occupancy, namely 1) increase in volumes of patients being seen in the Emergency Department; 2) increase in admissions and 3) 50% increase in the number of ALC patients, from 43 in Q1 to 61 in Q3. There is variation between the occupancy rates of the clinical programs with Medicine consistently being well above 100% (108% in Q3), and offset primarily by lower occupancy in pediatrics and obstetrics. A medicine occupancy rate of 108% translates into average use of 214 beds in Q3 compared to a funded bed complement of 196 and use of 18 overcapacity beds on average throughout the quarter. There remains sensitivity to the variation within programs such as SPA with higher occupancy Monday to Friday and lower occupancy on weekends.

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 however we hope our focus on ALC designation and other patient flow initiatives we will see KGH's the occupancy rate trending downward toward the target of 95%.

Definition: DATA: Decision Support COMMENTS: Brenda Carter 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%

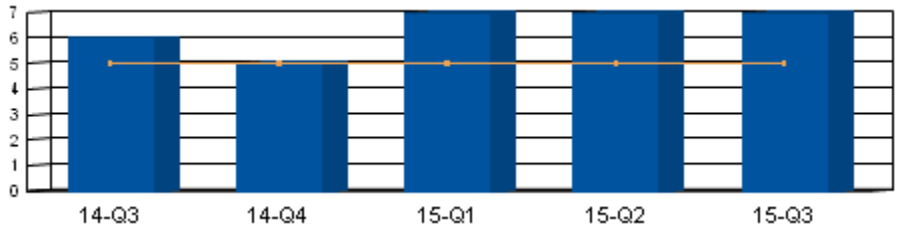
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	6	**5**
14-Q4	5	**5**
15-Q1	7	**5**
15-Q2	7	**5**
15-Q3	7	**5**

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

The OR Cancellation working group continues to monitor and evaluate strategies put in place in Q2 by the working group:
1) Quarterly meetings with secretarial office staff and program leadership- last meeting was November with guest speakers from Decision support to review education on using the Novari Booking system to improve the bookings for patient's surgeries.
2) Quarterly newsletter with updated volumes and wait time metrics to support office monitoring of bookings- increased secretary engagement has been achieved and next issue is due January 30th
3) Creation of one resource person for office staff support- established role has been in place and maximized office staff ability to find information in a timely fashion
4) Patient follow-up calls at one week and night before surgery- delayed due to initial OR resources but to be reintroduced in the next quarter utilizing a new potential resource.
5) patient communication letter highlighting OR surgery preparation sent out by secretarial office staff- concerns around using email needed to be addressed before this initiative could be rolled out across all offices.

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

In this 3rd quarter there were 115 out of 2,249 patients whose surgeries were cancelled. Within this volume there were 29 avoidable cancellations (33%) 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-2, incomplete pre-surgical screening-2, incorrectly booked-3, insufficient workup/needs more-2,patient not fasting -3, patient refused procedure-6, patient unavailable-5, patient did not show for surgery-2, no blood available-1 and surgery no longer required-1. Patient behavior- 2, other staff unavailable-1, anesthesiologist unavailable-2.

Also influencing the performance for this quarter was the ongoing state of "Code Gridlock" lasting 1864 hours resulting in the immediate cancellation of 12 patients plus an additional 8 patients for "no available bed" due to an internal program surge as a result of other service's patient needs.

Our target of 5% is well within the range of our peer teaching hospitals as is our current performance. This is a reasonable target. Our peer hospitals include:
London Health Science Center = 4.4
Hamilton Health Science Center = 9.8
St Michaels Hospital = 5.2
Sunnybrook Hospital = 5.0
Trillium General Hospital = 10.0
Ottawa = 3.7
Thunder Bay = 3.9
Sudbury = 4.2

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

The ongoing state of gridlock and unanticipated earlier case complications or emergency case substitutions will continue to influence this metric on a quarterly basis towards achieving the year-end target. Efforts to temporarily care for patients in the recovery room overnight to reduce cancellations has positively influenced this metric to stay in the yellow zone however it comes with an increased budget cost for additional nursing hours for the unit. Year to date there have been 249 patients who were not cancelled and cared for in the recovery room for up to 72 hours in some cases until they could be placed into a bed. This is a strategy that is not fiscally sustainable therefore the cancellation rate may start to increase.

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)

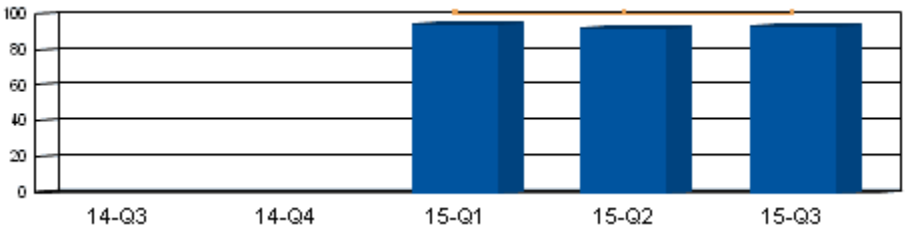
Target: Target 14/15: 5% Perf. Corridors: Red >9 Yellow 7-9 Green <6

Q3 FY2015 Strategy Performance Indicators Report

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

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

Five Patient- and Family Centred 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 we have begun training in 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. Over 500 staff has completed the training and the steering group is now evaluating the training and adapting it to best suit staff's learning needs. The new version of the training will begin rolling out in late January.

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 a total of 8090 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those audits 7581 were in compliance or 93%. The individual standards are being reported at a corporate compliance rate of at least 90%. (Badges 90%, whiteboards 92%, Communication 97%, hourly rounding 97%) For those areas not meeting the goal directors and managers look to find ways of supporting staff and physicians to increase their compliance.
The # of feedback forums completed stands at 11 as of December 31st. With the exception of Medicine all programs have completed at least one forum with Oncology, Critical Care, SPA and Mental Health having completed 2 each.

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 currently performing at a 93% compliance rate on 4 of the standards and are confident of our ability to maintain this performance. We would expect all 9 Programs to have completed at least one feedback forum by the end of Q3. Medicine which at the end of Q3 had not completed any forums presently has 2 in the works. Each Program has offered assurances that a minimum of 2 forums and 4 improvement cycles will be completed by year end.

Definition: DATA: Daryl Bell COMMENTS: Daryl Bell STRATEGY REPORT

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
- 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.

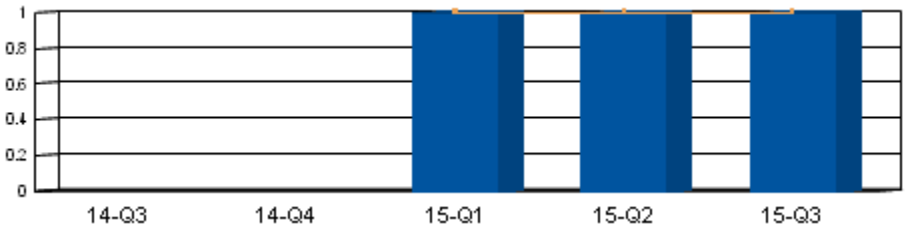
Target: Target 14/15: 100% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%

Q3 FY2015 Strategy Performance Indicators Report

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-Q3		
14-Q4		
15-Q1	1	**1**
15-Q2	1	**1**
15-Q3	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: Vendor has commenced creating joint venture's constitution, structure, governance and business plan by undergoing a landscape survey of hospital and university partners' research enterprises. Monthly meetings with three hospital CEOs, FHS Dean, and FHS vice Dean/KGH VP Health Sciences continue.

Develop a KGH Research Institute website with potential use for the joint venture: Vendor currently working on KGH's web renewal project (which includes KGHRI website). Information architecture for new KGHRI website completed. Meetings with internal and external stakeholders for feedback through engagement sessions completed. Finalized KGHRI branding. Our two external service providers (communications consultants) continue with rolling out other activities to assist with KGHRI website, KGHRI branding, and profiling research. In joint collaboration with Queen's University's Communications Office, monthly stories about KGHRI and our researchers are being published on the Queen's website.

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. UHKF has raised in pledges and past donations ~$2 million for project. Total cost for project ~$6M. We will build the new Centre in two phases. Phase 1 will proceed now with secured funds, while phase 2 will occur once remaining funds raised and/ or additional CFI grants awarded. Functional programmers have completed a functional & space program plan and a functional program (cost) estimate plan for the new Centre. Currently working on concept designs and layout for the new Centre with architects. Pre-capital submission to both Ministry of Health & Long-Term Care (MOHLTC) and Southeastern LHIN (SELHIN) occurred in October 2014. SELHIN approval obtained in December 2014. Now waiting for MOHLTC approval to proceed with pre-tender, tender, and construction. Anticipate going to tender in spring 2015 with final construction of phase 1 completed by end of December 2015.

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

Research Infosource released its Canada's Top 40 Research Hospitals and Kingston General Hospital was in the list again. This year our ranking dropped from 22nd to 27th due to the fact that CAHO requested its hospital members to report to Research Infosource revenue based on actual expenses (GAAP principals) as opposed to actual revenues received which we have done in prior years. Everyone else on the list (non-CAHO members) reported revenues as previously mentioned, so it will be like comparing apples to oranges. We have dropped several places in the ranking this year as a consequence.

On a more positive note, we have successfully reached our KGH 2015 target of increasing research revenue by 51% since baseline. This is a huge accomplishment over the past 5 years thanks in part to the nine clinicians scientists recruited to KGH through the SEAMO Clinician Scientists Recruitment Program.

Based on the fiscal year to date, KGH is on target by the end of the third quarter. The Joint Venture will enhance the coordination, visibility, promotion and growth of health research, collectively and at our 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 0 Yellow N/A Green 1(1 = Yes 0 = No)

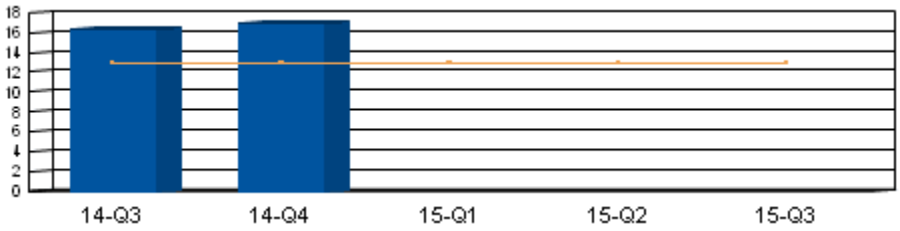
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	16.39	**12.9**
14-Q4	17.04	**12.9**
15-Q1		**12.9**
15-Q2		**12.9**
15-Q3		**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

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 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.

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. For Fiscal 15/16, we will be looking to implement a regional indicator within the SE LHIN.

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.

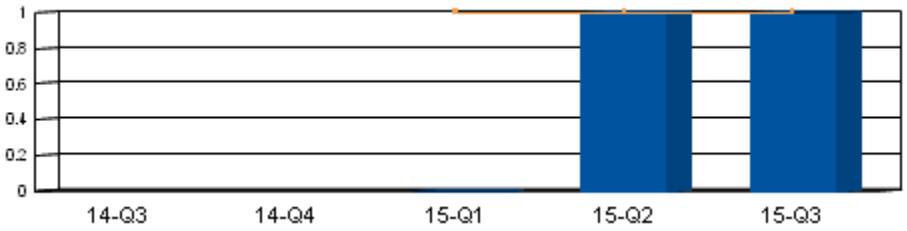
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%

Q3 FY2015 Strategy Performance Indicators Report

People

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

Indicator: Quarterly Engagement Plan Status



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

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

A touchstone survey and results were reviewed and communicated to targeted areas who had both higher and lower scores in 2013. Some gains were evident. Health and wellness activities such as yoga, a staff newsletter, lunch and learns during Healthy Workplace Month occurred. A review of education and learning continued and Leadership days took place. Frontline leadership programs were launched and psychological safety was a focus which will continue into next year. Volunteer orientation program revamp was completed. The process for developing an engagement strategy and working closely with Queen's Undergrad medical students was also undertaken.

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

Individual and team engagement plans continue as we move from a separate activity to being part of everything we do and the way we do things at KGH. The broader corporate areas of focus in health and wellness, trust, education and learning, recognition, volunteer and physician engagement and communication continue to move forward to address across the board improvements required. Recognition programs such as nominations for team awards, long service and other service events occurred in Q3 however, the overall review of our recognition program has not occurred due to resource capacity challenges. Touchstone survey results from representative areas across the hospital yielded positive results. Pulse results point to a 6% increase in overall positive responses from 2013 and where efforts were made to actively improve engagement, the results reflected this. The most significant result was an improvement of stress staff feel at work from 'extremely' and 'quite' stressful work environment to 'somewhat' stressful. This is a key measure in overall engagement and work environment.

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 solidification of tactics under education and learning related to our approach, and leadership development will occur in Q4. Communication and planning for the next survey approved and scheduled for April and tactics team formation will dominate Q4 activities on engagement. A booth at the interprofessional expo will assist in communication with staff and celebrating our gains to date. The volunteer mentor program discussions will continue in Q4.

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

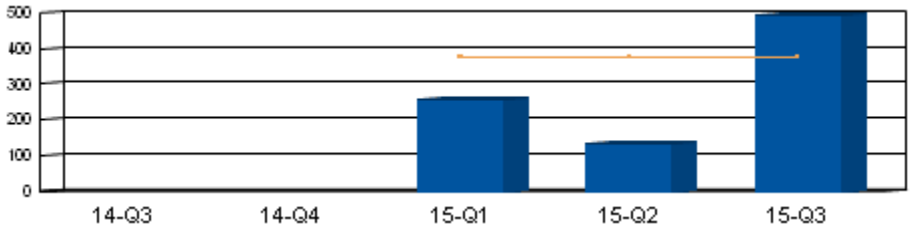
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3		
14-Q4		
15-Q1	259	**375**
15-Q2	132	**375**
15-Q3	495	**375**

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

Quarterly target met. 495 performance plans were received in Q3 after communication blitz and a focus on submitting those that were completed but not yet tracked. Emphasis on submitting plans after completion and solidifying actual leader targets assisted in meeting the target.

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

Performance conversations are part of employee engagement and continuous development for staff. This improves productivity and assists with our focus on learning and development in the corporate engagement plan. Targeted information sessions continued regarding completion of performance plans for staff and leaders. Leaders and staff who have been undertaking these performance conversations have cited numerous positive benefits that result in renewed energy in their work. This metric in part demonstrates the degree to which staff is engaged as individuals in their work and improvements in the work environment, care and knowledge at 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?

Trending very positively and more than 100 were received in the first 3 weeks of Q4. As of February, we are at about 1150 toward the overall target. If we maintain this momentum, we will finish close to the 1500 target. Regardless if the target is reached, we have significantly changed the view of performance and goals (some staff who had not had a performance conversation for many years, if ever) leading to a renewed energy toward completion for all staff by the end of next 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.

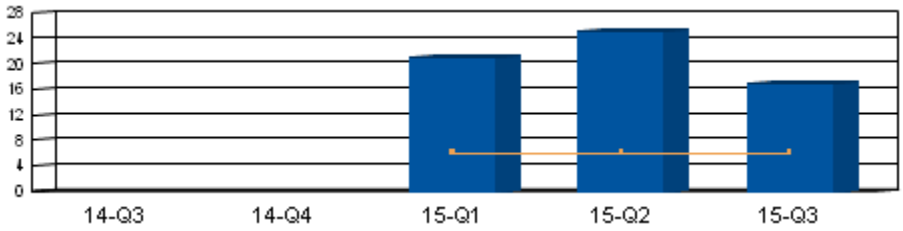
Target: Target 14/15; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375

Q3 FY2015 Strategy Performance Indicators Report

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-Q3		
14-Q4		
15-Q1	21	**6**
15-Q2	25	**6**
15-Q3	17	**6**

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

Ergonomist has been working with units experiencing increased injury to provide them with hands on training on their unit; review of equipment and other areas to safe patient handling are being identified. Ergonomist participating in new hire orientation on safe patient handling. Patient handling training in the LMS was finalized.

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

MSIs resulted in 14 health care claims and 3 lost time injury claims. There was a small reduction from quarters 1 and 2. Of these claims, 76% involved patient handling activities and of these, 77 % occurred during repositioning of the patient where the highest incidence was in Medicine (n=6). Outside of patient handling, the 2nd most common cause of these claims was lifting with highest incidence occurring in Environmental Services staff (n=4).

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; we have already surpassed our annual target of 24 claims or less. Plan is for focus on those areas experiencing high injury rates through "focused improvement reviews." A review of equipment and identification of gaps/opportunities for reducing patient handling-related MSIs will completed in Q4 with recommendations put forward. One outcome of reviews has led to the purchase of new beds to improve patient handling.

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.

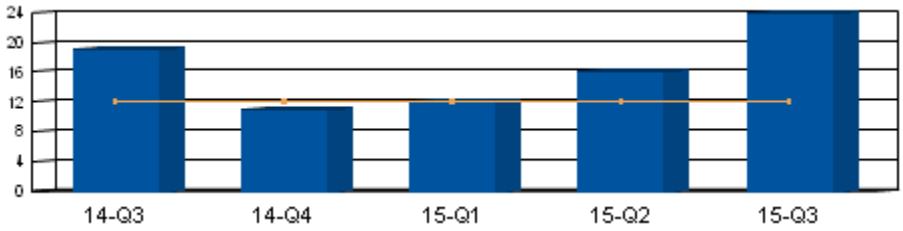
Target: Target 14/15: 6 Perf. Corridors: Red >7 Yellow 7 Green <=6

Q3 FY2015 Strategy Performance Indicators Report

People

All preventable harm to staff is eliminated

Indicator: Number of Needlestick Injuries



	Actual	Target
14-Q3	19	**12**
14-Q4	11	**12**
15-Q1	12	**12**
15-Q2	16	**12**
15-Q3	24	**12**

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

Needle Safety Training was launched to all clinical staff in early December. Conversion from Insulin needles to pens went live December 9. Incident Investigations are required for all needlestick Injuries as a mechanism to identify opportunities for reducing risk/improving safety.

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

Incidence is twice that of our goal and higher in Q3 as compared to Q1 and Q2. Sixty (60%) of NSIs occurred in October and the most common needles involved were suture needles. At least 50% of NSIs involved safety engineered needles that had not yet been activated. Residents were involved in 33% of NSIs and Programs with highest incidence were SPA (40%) and Critical Care (21%).

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; we have already had 52 NSIs this year surpassing our goal of 48 or less. The OR will be working with Medical Admin to coordinate suturing workshops for Residents and Medical Students that would be delivered by the First Assist RNs. Also will explore the opportunity for increased use of blunt suture needles where clinically feasible. Expect the conversion from insulin needles to pens will eliminate them as a source of injury going forward. To date since conversion to the pens, no needlesticks have occurred from the use of that device. Other tactics will include a review of what patients are able to do themselves and policies to enable what would occur outside hospital can continue during their stay.

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

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 Labour 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 bloodborne 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

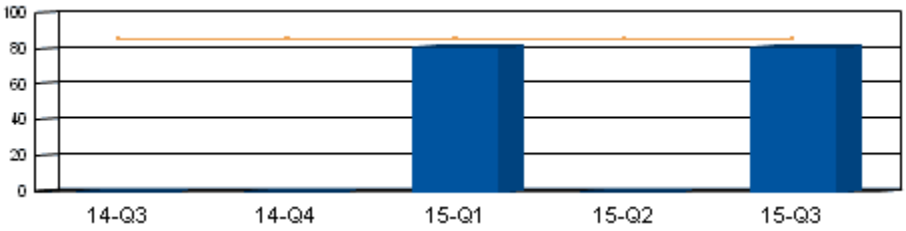
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

Facilities

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

Indicator: Percent Compliance with Cleaning Audits



	Actual	Target
14-Q3	0	**85**
14-Q4	0	**85**
15-Q1	81	**85**
15-Q2	0	**85**
15-Q3	81	**85**

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

The plan to have 50 in-house audits in addition to the Westech audits was not met during the quarter due to the unplanned departure of the internal auditor however this is now back on track in Q4.

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

Improvement realized and scores met or exceeded target in the high and very high risk categories such as OR, patient rooms and Sterile Core however there was some slippage in the low risk (primarily office and maintenance areas).

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

Additional training and workload distribution updates will be required to reach target. Westech is conducting full training to 5 managers and leads mid- February. The installation of the Lead positions will allow supervisors more ability to follow up with ESA's on audit results to more effectively complete the performance management and teaching process. In addition, the updating of ESA Duty Lists will provide higher accuracy, quality and a better balance of ESA workloads. Additional in-house audits will begin in March and the results of future Westech audits will be distributed to POD's in sizes and formats that will be more meaningful and user friendly. Plan is being developed to enhance PIDAC training and compliance of ESA staff through use of a patient room simulation set-up. This will allow for completion of the audit cycle follow up with ESA's.

Definition: DATA: Bob Campeau COMMENTS: Bob Campeau 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%

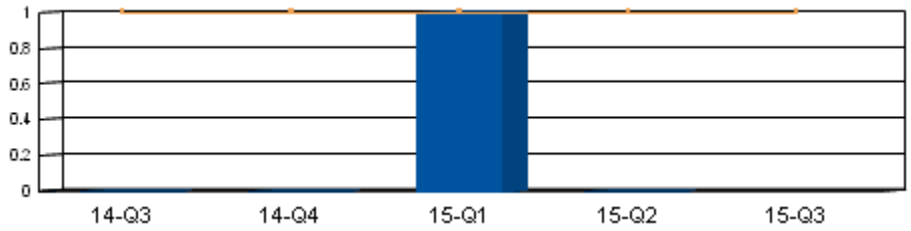
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

Facilities

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

Indicator: Stage 2 Approval Status



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

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

Activities to support progress on this tactic are focused on supporting the Ministry process and needs required to consider Stage 2 approval. Any new information requests in Q3 from the Ministry have been completed. Appropriate follow up has also been completed with Ministry staff and leadership to ensure the project continues to be actively reviewed.

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 continue to wait for approval to move on to Stage 2 of the planning process. We have completed all the required work requested in Stage 1. Our staff and Planning Office continue to support the Foundation as it prepares fundraising positions / cases for the project that can be used once Stage 2 work is able to advance. Obtaining Stage 2 approval remains the priority as the issues identified in the Concept submission in 2010 and the Stage 1 documents in 2013 still need to be addressed.

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 if the status of this indicator will change before Year-End. The Ministry is in process of evaluating hospital projects to determine which projects will be approved to move forward in the next planning cycle. To continue to advance our position and project we have arranged to further inform the process by meeting with the Ministry leadership to inform the process in Q4 and to provide tours of our site to ensure a full understanding or our submissions. This activity while it advances our position, we still must await the completion of the Ministry evaluation to determine if we advance on to Stage 2 for the project.

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.

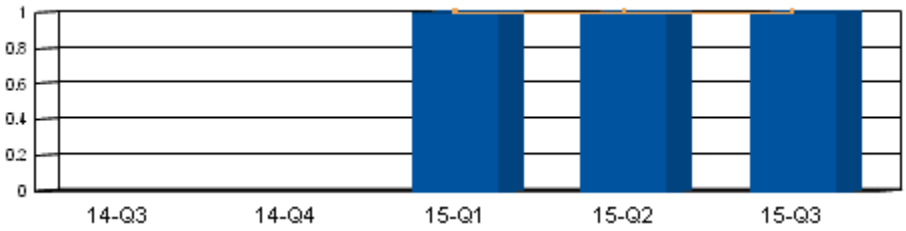
Target: Target 13/14 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes,Target 14/15 (1/0 = Yes/No) Perf. Corridor: Red 0 Yellow N/A Green 1(1 = Yes 0 = No)

Q3 FY2015 Strategy Performance Indicators Report

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

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

The clinical and technical requirements that hospitals in our region require of the system have been finalized and the RFP has been assembled and ready for release. The hospital's CEOs asked for additional information related to the funding and governance required to operate a regional HIS prior to obtaining individual board approval. To better align with the Health Care Tomorrow project, the regional HIS project will become part of the newly created Information Services Business Functions Working Group along with all other IT services, Health Records and Registration. The final decision regarding the release of the HIS RFP is expected by end of fiscal 2015, subject to the healthcare tomorrow timelines. KGH has successfully negotiated a contract extension with our current HIS vendor to mitigate risk to hospital operations until a final decision is made.

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 technical requirements that were collected 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 SE LHIN anticipating that the RFP will be ready for release by the end of Q4 if approved by SECHEF and all hospital boards.

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 for SECHEF and all hospital boards to approve release of RFP.

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

Target: Target 14/15: As per implementation schedule

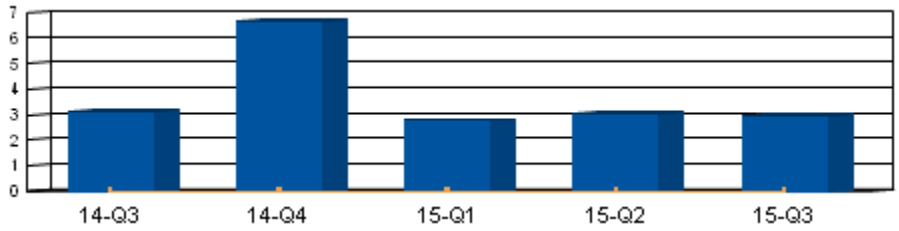
Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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-Q3	3.1	**0**
14-Q4	6.7	**0**
15-Q1	2.8	**0**
15-Q2	3.1	**0**
15-Q3	3.0	**0**

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

Monthly financial reporting and analysis support continued to be 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:

Essentially all identified operational efficiencies incorporated in the approved budget have been actioned. Those not meeting the original planned timeframe have been identified and actions addressed to implement.

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

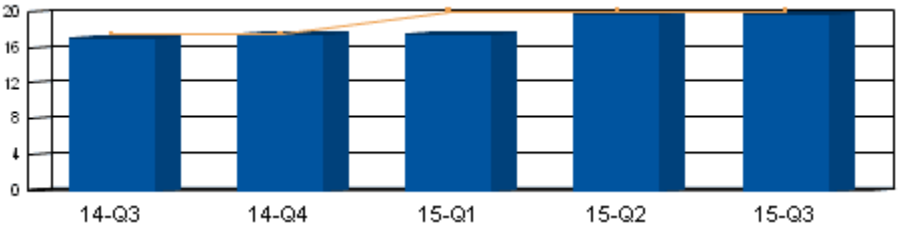
The hospital is optimistic of sustaining the balanced operating position through to the end of the fiscal year. Changes to the hospital bed map are being implemented and continued focus on working within budget parameters is ongoing.

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

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



	Actual	Target
14-Q3	17.1	**18**
14-Q4	17.5	**18**
15-Q1	17.5	**20**
15-Q2	19.7	**20**
15-Q3	19.7	**20**

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

There were no further operational efficiencies identified during the quarter to facilitate increased investment this fiscal 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:

The hospital has essentially met its target for increasing the annual capital capacity for investment in technology, patient care equipment, and technology at $19.7 million as at December 31st.

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

Discussions are ongoing with University Hospitals Kingston Foundation which could provide further support of purchases from donor gifts.

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: $20M Perf. Corridor: Red <$15M yellow $15M-$17.4M Green >=$17.5M

Kingston General Hospital

Q3 FY2015 Strategy Performance Indicators Report

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