fiscal 2014-2015 **Q2**

2nd quarter ended September 30, 2014

KGH this quarter

Strategy Performance Report

Kingston General Hospital

Outstanding care, always

KGH Strategy Performance Report Fiscal 2015 Q1

KGH Strategy Performance Report Fiscal 2015 Q1

Strategic Direction 2

Bring to life new models of interprofessional care and education

Outcome 4:

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

Strategic Performance Indicators

Strategic Direction 3

Bring to life new models of interprofessional care and education

Outcome 5:

Externally funded research at KGH has increased 50%

Strategic Performance Indicators

Strategic Direction 4

Increase our focus on complex-acute and specialty care

Outcome 6:

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

Strategic Performance Indicators

Strategic Direction 5

People

Outcome 7:

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

Strategic Performance Indicators

KGH Strategy Performance Report Fiscal 2015 Q1

Kingston General Hospital

Q2 FY2015 Strategy Performance Indicators Report

Strategic Direction	2015 Outcome	Indicator	14-Q2	14-Q3	14-Q4	15-Q1	15-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety and service improvement initiatives	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	G	G	N/A	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	G	Y	G	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	N/A	G	R	
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	G	G	G	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)	Y	R	R	Y	Y	↓
		Number of Incidents Associated with Morphine or Hydromorphone	N/A	N/A	N/A	R	G	
		Number of Specimen Collection and Labelling Errors	N/A	N/A	N/A	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)	Y	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	R	Y	R	R	R	↓
		Overall Medical/surgical Occupancy Rate (Midnight Census)	N/A	N/A	N/A	Y	R	
		OR Cancellation Rate	Y	G	G	Y	Y	↓

Strategic Direction	2015 Outcome	Indicator	14-Q2	14-Q3	14-Q4	15-Q1	15-Q2	
Bring to life new models of interprofessional care and education	Our Interprofessional Collaborative Practice Model (ICPM) is implemented in every clinical area with high ratings from patients, staff, and learners	Percent Compliance within Each of the 5 Standards across Clinical Areas	N/A	N/A	N/A	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	N/A	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)	R	N/A	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	N/A	Y	G	
		Number of Staff with Performance Reviews and Agreements on File	N/A	N/A	N/A	Y	R	
	All preventable harm to staff is eliminated	Number of WSIB Health Care and Lost Time Injury Claims due to MSI	N/A	N/A	N/A	R	R	
		Number of Needlestick Injuries	R	R	G	G	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	Y	R	R	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	N/A	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	Y	G	Y	G	↑

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

Q2 Status Breakdown

Strategy Indicators

	#	%
Red	14	52%
Green or Yellow	13	48%
N/A	0	0%
	27	

QIP Indicators

	#	%
Red	8	67%
Green or Yellow	4	33%
N/A	0	0%
	12	

Supporting Indicators

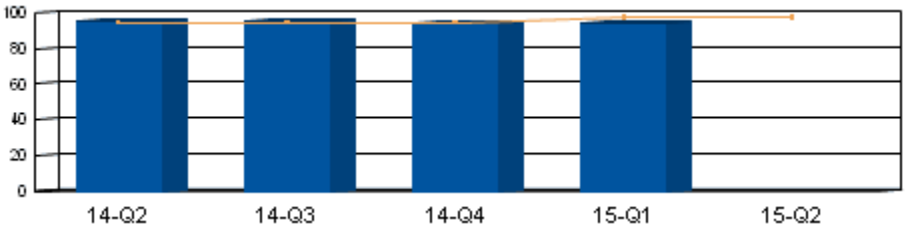
	#	%
Red	27	33%
Green or Yellow	55	66%
N/A	1	1%
	83	

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

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

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

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

As of September 30th, 224 KGH staff, learners and volunteers have completed the Communicate with HEART training. This represents 45% of the target for the tactic. It is worth noting that there is positive feedback from patients and families indicating they are noticing a difference in the interactions with staff. Patient feedback appears to be more frequent and not always negative. Which fits the H.E.A.R.T roll out.

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

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

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

The patient's perception of overall care received and is based on a single question (#44) on the National Research Corporation of Canada (NRCC) Acute Inpatient survey. Possible responses to this question include poor, fair, good, very good and excellent. The percent positive score represents the combined responses of good, very good and excellent.
Ambulatory Care is reported separately, with Oncology reported bi-annually and Emergency Care reported quarterly.

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

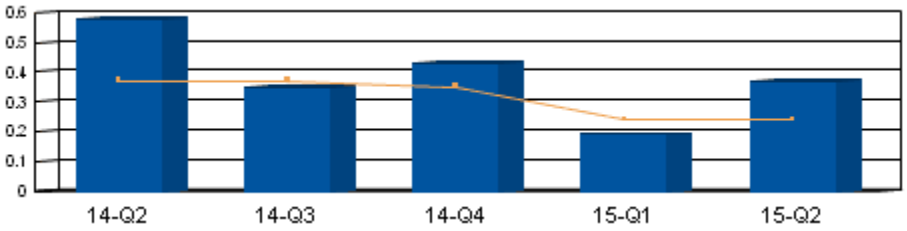
Kingston General Hospital

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

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

The increase in rate was primarily due to a small cluster on one unit. Mitigation included additional measures on that unit to clean the core areas, and all equipment shared between patients. A review of antibiotic use and proton pump inhibitors was also conducted with each case. Public Health was notified who confirmed this increase in cases did meet criteria to declare a unit specific CDI outbreak.

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

Currently, we are more than 2 years without an outbreak of CDI. Use of CDI preprinted orders and ongoing monitoring of antibiotic use will continue to be important to improving patient outcomes.

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. There are challenges with the Antibiotic Stewardship Program due to an unforeseen reduction in human resources and lack of electronic system support. Efforts are under way to address both of these issues.

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

Q2 FY2015 Strategy Performance Indicators Report

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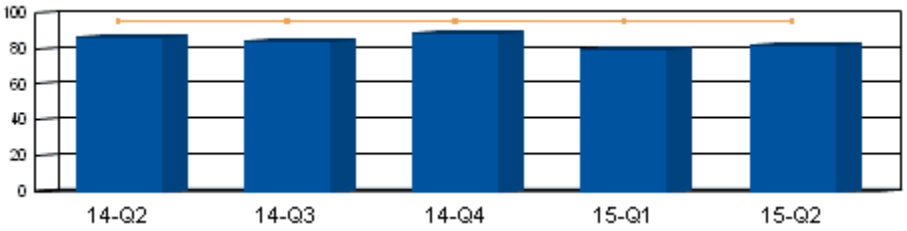
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
14-Q2	86.3	**95**
14-Q3	83.7	**95**
14-Q4	88.2	**95**
15-Q1	79.7	**95**
15-Q2	82.0	**95**

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

IPAC Service continues to support all hand hygiene auditors and have been working to increase the number of observed opportunities captured each month. Corporate targets have been set as 100 observed opportunities per month for most in-patient units and 50 opportunities per month for outpatient units.

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 this quarter we captured 1843 indications of Moment 1(before initial patient/patient environment contact). KGH's 2013 -2014 annual total for Moment 1 were 5466 indications. It is important to note that the annual numbers submitted to the MoHLTC include only the data for in-patient units and does not include the data from our numerous clinic areas. KGH's annual submission to the MoHLTC was submitted the end of March. Our HH compliance total for in-patient units was 82%. Overall, Q2 compliance rates have improved and return to rates above 80%. (September corporate rate is 90%).

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. Ongoing reinforcement of compliance by the IPAC team and auditors in combination with improved public reporting and posting of results in the hospital will continue. Hand Hygiene Working Group has been meeting and are identifying new opportunities to improve hand hygiene compliance.

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%

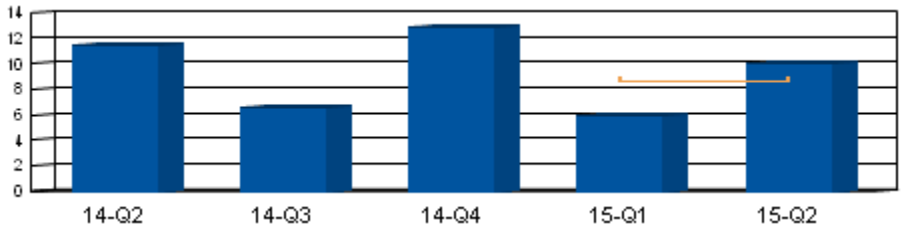
Kingston General Hospital

Q2 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: Rate of 5-day In-Hospital Mortality Following Major Surgery per 1000 Major Surgical Cases (QIP)



	Actual	Target
14-Q2	11.40	
14-Q3	6.60	
14-Q4	12.90	
15-Q1	5.90	**8.68**
15-Q2	10.07	**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 Q2 rate is greater than the provincial target. Q2 results have not yet been received at JQUIC. Any recommendations will come forward to MAC for consideration

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

yes.

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

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

Q2 FY2015 Strategy Performance Indicators Report

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

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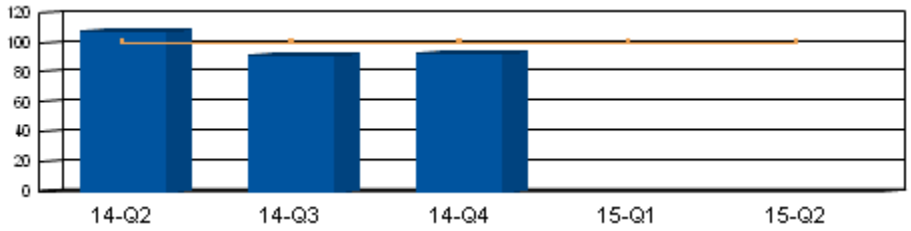
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



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

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

The Hospital Standard Mortality Ratio (HSMR) is an important quality of care measurement tool that provides a starting point to assess mortality trends, identify opportunities for improvement and track progress. The HSMR is adjusted for factors affecting mortality, such as age, sex, and length of stay. An HSMR equal to 100 suggests that there is no difference between the hospital's mortality rate and the overall average rate. An HSMR greater than 100 suggests that the local mortality rate is higher than the overall average whereas a HSMR less than 100 suggests that the local mortality rate is lower than the overall average. It is important to note that HSMR is not designed for comparisons between hospitals; it is intended to track a hospital's trend over time. Currents tactics underway to address the HSMR are as follows: Mortality reviews in all KGH clinical departments (Medicine - focus on Sepsis, Surgery - all plus post major surgery, other Departments - all deaths), application of the VAP prevention protocol including a checklist, and conducting MRSA admission screening on all admissions.

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

The most recent data available data from CIHI is Q4 of fiscal 13/14. Fiscal 14/15 Q1 and Q2 results arrive at the same time and are not expected until Q4. The HSMR for Q4 was deemed not significant by the Canadian Institute for Health Information (CIHI). The Canadian Institute for Health Information (CIHI) provides the HSMR calculations to all hospitals in Ontario. Quarterly morality reviews are on-going by the clinical departments. Any concerns or trends are reported to the MAC's Joint Quality and Utilization Committee. Of note is a continued drop on the 5 year annual mortality rate.

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

Yes.

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

The Hospital Standardized Mortality Ratio (HSMR) is an overall quality indicator and measurement tool used by all acute care hospitals and regions in Canada (excluding Quebec). HSMR has been used by many hospitals in several countries to help improve quality of care and enhance patient safety. The HSMR is based on diagnosis groups that account for 80% of all deaths in acute care hospitals and is adjusted for factors such as diagnosis group, age, sex, length of hospital stay, admission category, comorbidities (having multiple illnesses at once) and transfers. The Formula for HSMR is equal to the number of observed deaths divided by the number of expected deaths, multiplied by 100.

Target: Baseline 08/09: 111 , Target 09/10: 100, Target 10/11: 100, Target 11/12: 106. Target 12/13: 100, Target 13/14: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant, Target 14/15: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

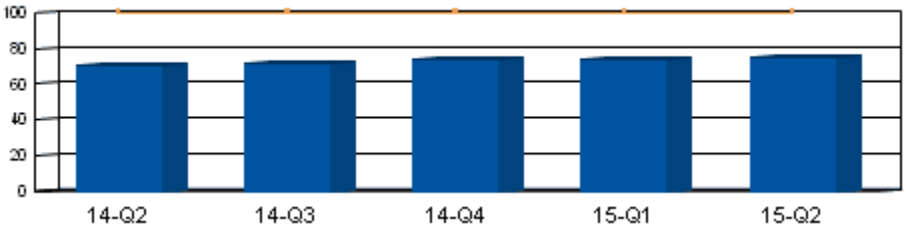
Kingston General Hospital

Q2 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: Medication Reconciliation at Admission (QIP)



	Actual	Target
14-Q2	70	**100**
14-Q3	72	**100**
14-Q4	74	**100**
15-Q1	74	**100**
15-Q2	75	**100**

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

Medication reconciliation reduces medication discrepancies at interface of care and prevents patient harm. Medication reconciliation on admission requires the documentation of the complete home medication list or Best Possible Medication History (BPMH) on the admission orders. Standardized admission order sets support the process by prompting the prescribers to document the BPMH on the admission orders.
The development of admission order sets including the medication reconciliation process is slowly progressing in Surgery services. One new order set was approved in Q2 (Orthopedics service).
Existing surgical admission order sets are available to the prescribers on all surgical patient care units.
A standard surgery admission order set is being considered.

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 medication reconciliation on admission indicator is a measure of the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the Hospital (excluding Mental Health patients). The percentage of patients who receive medication reconciliation at admission has increased from 74% in F15 Q1 to 75% in F15 Q2.

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

A medication reconciliation policy cannot be developed by the Medication Safety Committee until all medical services have access to admission order sets embedding the medication reconciliation process.

Surgical admission order sets are required to address low scores achieved in F15 Q2 by the following services: Otolaryngology 17%, Plastic surgery 31%, Thoracic surgery 45% and Urology 16%.

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%

Q2 FY2015 Strategy Performance Indicators Report

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

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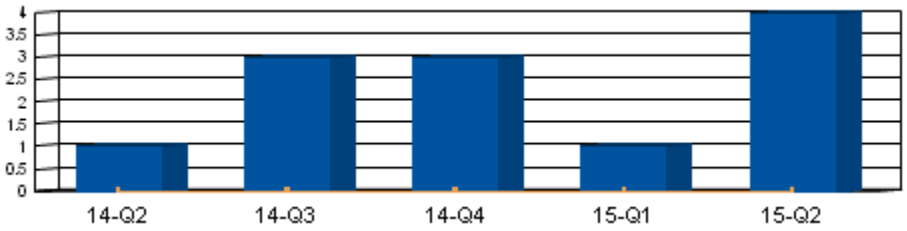
Indicator: Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)



	Actual	Target
14-Q2	1	**0**
14-Q3	3	**0**
14-Q4	3	**0**
15-Q1	1	**0**
15-Q2	4	**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 second quarter; all have been reviewed for actual severity level and to identify causal factors that can be used to support improvements. All 4 falls involved ambulating patients (with our without an aid - such as a walker). 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 Q3 & 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

Kingston General Hospital

Q2 FY2015 Strategy Performance Indicators Report

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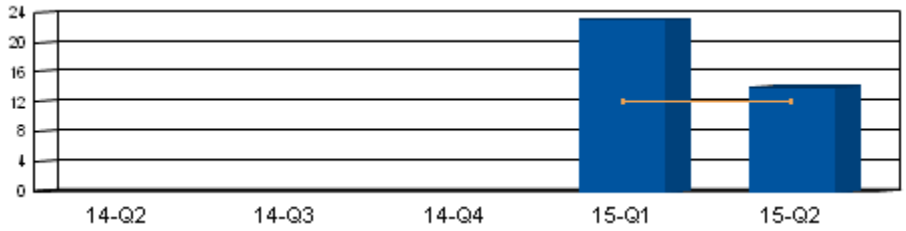
Indicator: Number of Incidents Associated with Morphine or Hydromorphone



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

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

Automated Dispensing Medication Cabinets support the implementation of safeguards with goal to prevent the dispensing and administration of incorrect drugs, formulations, doses, frequency and routes.
Morphine and hydromorphone are potent analgesics most frequently associated with serious incidents causing patient harm.
As KGH continues to implement automated dispensing cabinets (ADCs) throughout the hospital, reported morphine and hydromorphone administration incidents have decreased from 23 in Q1 to 14 in Q2.
A Quarterly Safe Reporting System report for hydromorphone and morphine is now reviewed quarterly by the Medication safety Committee.
In September 2014, the Medication Safety Committee reviewed safeguards options for hydromorphone as recommended by the Institute for Safe Medication Practices (ISMP Canada) and the Accreditation Canada Medication Management standards.

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 Q2.
Fourteen reported medication administration incidents associated with morphine or hydromorphone is above the target of 12 for this quarter. Of note,

- Three patients received higher doses of hydromorphone than were prescribed
- Six patients received hydromorphone sooner than was prescribed

None of the incidents were reported as level 3 (moderate harm) or level 4 (serious/critical incidents).
Administration incidents were mostly reported with hydromorphone compared to morphine and included 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 implementation of Automated Dispensing Cabinets continues with goal to complete project by the end of Q3. The Medication Safety Committee will present safeguard options to the Nursing Practice Council in October with goal to implement one safeguard for hydromorphone by the end of Q3. Note that Kidd 2 ICU is the only inpatient care unit without a cabinet however, implementation plans are in place.

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

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

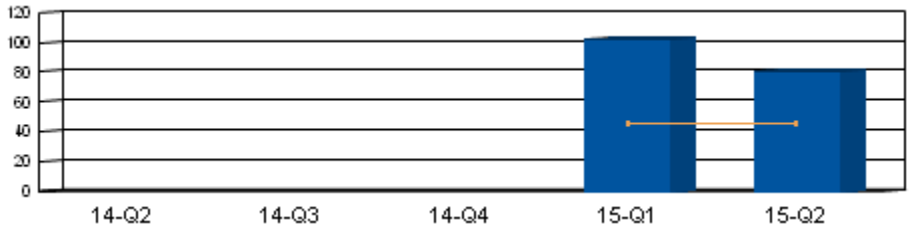
Target: Target 2014/15: 12 Perf. Corridor: Red >20 Yellow 16-20 Green <=15

Q2 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: Number of Specimen Collection and Labelling Errors



	Actual	Target
14-Q2		
14-Q3		
14-Q4		
15-Q1	102	**45**
15-Q2	80	**45**

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

While the indicator for this quarter remains at a RED indicator level work continues to reduce the overall specimen collection errors. Result is trending and heading in the right direction further reducing errors from 102 to 80 in this quarter. During Q2 a Laboratory Manager was hired with the focus of the Pre-Analytical aspect of specimen collection and the Lab Order project was completed.
The Lab order entry project was completed at the end of this quarter which will help address unlabeled specimens.
While the target of reducing the number of specimen collection errors is an aggressive stretch, progress continues to be 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:

Specimen labelling errors can result in unnecessary testing or procedures performed delays in treatment or diagnosis. Delays also may impact a patient's quality of life. Whenever there is a mislabeled specimen there are potentially 2 patients involved. Consequences can apply to both.

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

Looking at opportunities to target areas that do not fall within the phlebotomy implementation group, i.e. critical care. Dialogue with area has started.

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

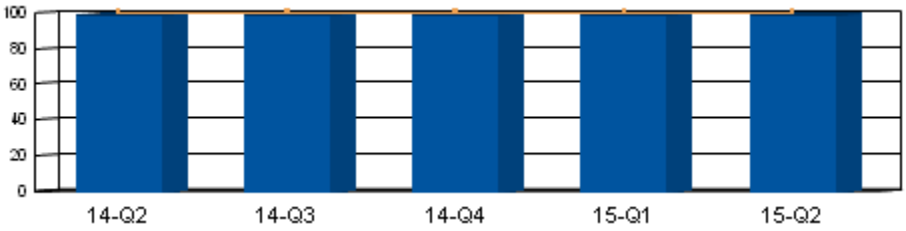
Kingston General Hospital

Q2 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-Q2	99	**100**
14-Q3	99	**100**
14-Q4	99	**100**
15-Q1	99	**100**
15-Q2	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 Q2 this indicator continues to meet the green target corridor. There were 2,397surgical cases completed in this quarter. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.6%, Timeout-99.2%, and Debrief- 99.7%. The unscheduled/emergent cases and consistent compliance to the surgical safety checklist completion continues to be an area of focus for the next quarter. New pediatric surgical safety list has been created and approved by SPA Program Council with a planned implementation time of November.

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.

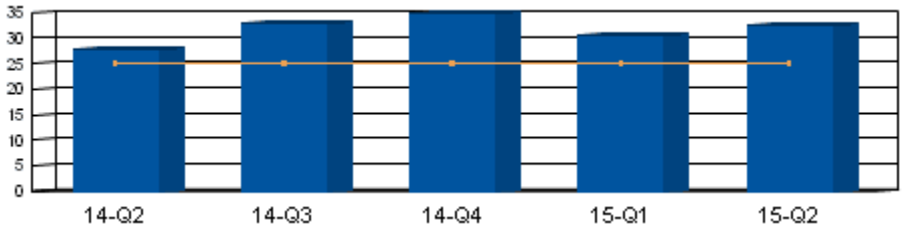
Target: Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%

Q2 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-Q2	28.0	**25**
14-Q3	33.0	**25**
14-Q4	35.0	**25**
15-Q1	30.7	**25**
15-Q2	32.6	**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. Working groups are looking at processes around decision to admit as priorities for improvement as well as minimizing bed empty time. All consulting services have been provided with data specific to their service and asked to make a 20% improvement in disposition decision. Projects have been implemented to standardize the predicted discharge and discharge planning process. 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.

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 Q2 result of 32.6 hours is just under 8 hours longer than the 25 hour target. Ninety percent of all patients admitted through the ED waited up to 32.6 hours to be transferred to an inpatient bed. Ten percent waited longer than this. Based on Q2 admission volumes of 2888, 288 patients waited longer than 32.6 hours in the ED for an inpatient bed. Inpatient days in the ED are 1027 this quarter which is the equivalent of 11 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.

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

Uncertain at the end of Q2. If trend continues we will not meet the target. 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 approaching 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.

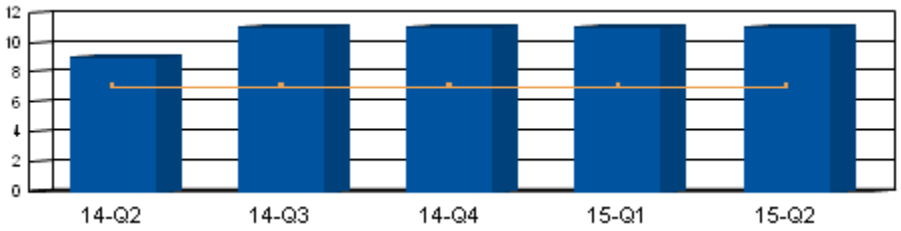
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28

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

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

The tactical plan includes the development of an interprofessional team to address the discharge process. A weekly meeting was held to discuss the ALC-LTC and the ALC for Complex Care patient populations. In addition, the patients waiting for transition to Providence Care Rehab programs were discussed with the Orthopedics team.

Rounds were very helpful in identifying barriers to discharge: patient choices, patient care needs that precluded acceptance by the LTC home of choice, and patient behaviours. There was success with two very long-stay ALC patients (excess of 600 days combined) this past quarter whereby they transferred to their ALC destination.

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

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

The Q2 result of 11% indicates that, on average, there were more than 40 inpatients at KGH whose acute care stay was complete and who were waiting for access to one of the destinations listed below.

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

The majority of ALC patients are awaiting transfer to a long term care home (LTC), and the LTC patients have the longest length of stay at KGH while they wait for an opportunity to move to their destination (LTC Home) of choice.

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

It is uncertain, at best, as to whether we will meet the target of 7% this year. ALC activity has nearly doubled in Q3 to date.

Actions underway for the coming quarter, as per discussion at the patient flow task force include:
- Assignment of a staff person to take the lead in focusing on ALC processes
- Development of a tiger team to look at the current status of the ALC patients at KGH - to review/revise any processes and to advise on the necessary steps to support consistent adoption of ALC designation processes
- refresh the education of ALC designation criteria to ensure that care providers do not create expectations on the part of the patient or family.

Definition: DATA: Decision Support COMMENTS: Adrienne Leach STRATEGY REPORT

When a patient occupies a hospital bed and does not require the intensity of resources/services provided in the acute care setting, the patient must be designated alternate level of care (ALC) by the physician or his/her delegate. The ALC wait period starts at the time of designation and ends at the time of discharge/transfer to a discharge destination, or when the patient's needs or condition changes and the designation of ALC no longer applies. The percent of ALC days (total ALC days/total inpatient days) is calculated to better understand the proportion of ALC days for a given period of time.

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

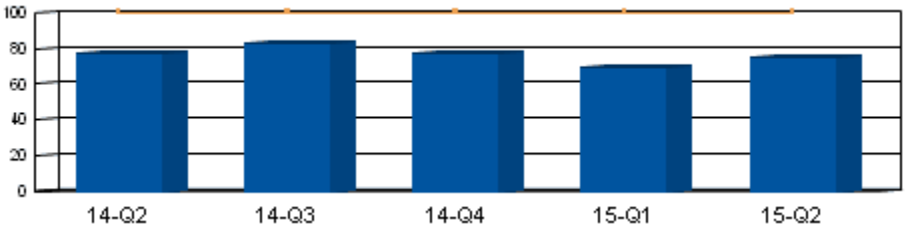
Kingston General Hospital

Q2 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-Q2	77	**100**
14-Q3	83	**100**
14-Q4	77	**100**
15-Q1	69	**100**
15-Q2	75	**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 increase in the number of services meeting the 90th percentile wait time target in Q2. 13 of 52 clinical areas have a status of Red with respect to meeting their wait time targets: 2 general surgeries; 1 neurosurgery, 2 dental oral surgery; 4 orthopedic; 1 plastic, 2 urology, and 1 DI (MRI). The Wait Time Committee continues to review the current change and focus on sustainability of initiatives that lead to the improvements in wait times

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 are 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%

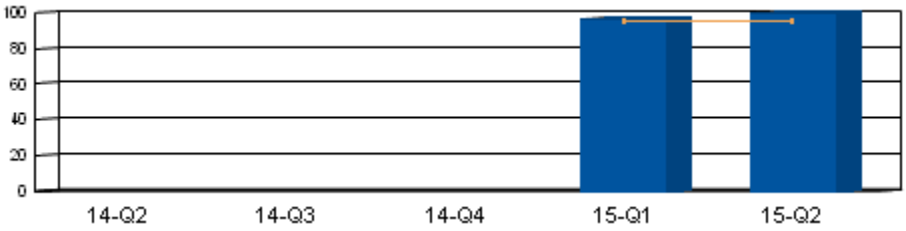
Kingston General Hospital

Q2 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-Q2		
14-Q3		
14-Q4		
15-Q1	96	**95**
15-Q2	100	**95**

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

The Q2 overall medical/surgical occupancy rate of 100% exceeds the target of 95% and reflects an increase from the Fiscal 14 yearend performance of 98%. Occupancy at this rate reflects the challenge with having capacity to support patient access to beds and patient flow. In spite of initiatives that are directed to and having a positive impact with length of stay, the increase volumes of patients being seen in the Emergency Department, the increase in admissions and 50% increase in the number of ALC patients is resulting in high occupancy rates. It is critical to note that there is also a disparity between the occupancy rates of the various programs with Medicine consistently being well above 100% (109% in Q2), and offset primarily by pediatrics and obstetrics. There remains sensitivity to the variation within programs such as SPA with higher occupancy Monday to Friday and lower occupancy on weekends; however this variation has been less pronounced in Q2 with patients being retained in overcapacity spaces in the operating recovery area.

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

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. In Q2 there were positions changes related to retirement and reassignments within KGH and the CCAC, and these transitions may have had impact on the rigor of processes with ALC designation and discharge/transition planning. There have been new assignments to support the processes, and a task team is specifically focusing on ALC designation and flow. There were 14 temporary beds opened on Connell 3 to enable flow from the ED, and these beds will transition to permanent status when the staffing is in place to support the new bed map (expected no later than early Q4). Attention is being given to supports for the clinical and support teams because the levels of activity and acuity, coupled with more frequent and extended Gridlocks are understandably creating stress and fatigue. The hospital remains transparent with regional partners and the LHIN on Gridlock status and is working with their teams on the initiatives related to behavioral support in community, ALC flow. ALC is flagged as risk to be managed to support the LHIN sustainability project.

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: Eleanor Rivoire STRATEGY REPORT

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

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

Kingston General Hospital

Q2 FY2015 Strategy Performance Indicators Report

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

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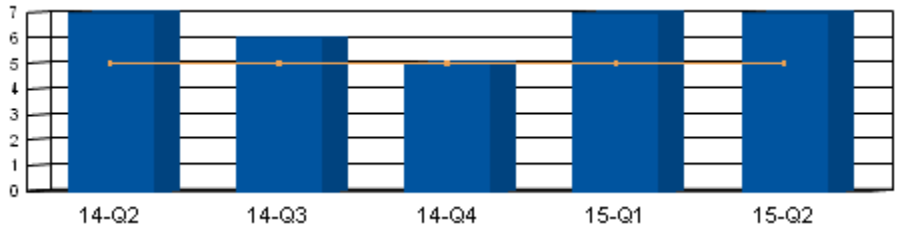
Indicator: OR Cancellation Rate



	Actual	Target
14-Q2	7	**5**
14-Q3	6	**5**
14-Q4	5	**5**
15-Q1	7	**5**
15-Q2	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 work towards reducing avoidable cancellations and is now in the monitoring phase of the tactics implemented below:
1) Quarterly meetings with secretarial office staff and program leadership
2) Quarterly newsletter with updated volumes and wait time metrics to support office monitoring of bookings
3) Creation of one resource person for office staff support
4) Patient follow-up calls at one week and night before surgery
5) Patient communication letter highlighting OR surgery preparation sent out by secretarial office staff

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

This quarter there were 178 out of 2,398 patients whose surgeries were cancelled. Within this volume there were 33 avoidable cancellations (19%) 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 presurgical screening-2, incorrectly booked-6, insufficient workup/needs more-1,patient not fasting -1, patient refused procedure-6, patient unavailable-5, patient did not show for surgery-2 and surgery no longer required-3.. Also influencing the performance for this quarter was the 6 episodes of "Code Gridlock" lasting 498 hours resulting in the immediate cancellation of 14 patients plus an additional 19 patients for "no available bed" due to an internal program surge as a result of other service's patient needs.

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 unpredictability of gridlock events and unanticipated earlier case complications or emergency case substitutions will influence this metric on a quarterly basis towards achieving the year-end target. 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.

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

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

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

Kingston General Hospital

Q2 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-Q2		
14-Q3		
14-Q4		
15-Q1	94	**100**
15-Q2	92	**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 and are currently rolling the education out to all staff and physicians.

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

This quarter a total of 8470 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those audits 7768 were in compliance or 92%. The individual standards are being reported at a corporate compliance rate of over 89%. (Badges 89%, whiteboards 93%, Communication 90%, hourly rounding 96%) 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 9 as of Sept 30th. With the exception of Medicine and Emergency all programs have completed at least one forum with Oncology and Critical Care 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 92% compliance rate on 4 of the standards. This represents a 2% decrease in the compliance rate since Q1. Managers have been made aware of this trend and are supporting staff to increase their compliance. We would expect all 9 Programs to have completed at least one feedback forum by the end of Q2. Those Programs which have not completed one are actively seeking out candidates for their feedback forums. 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%

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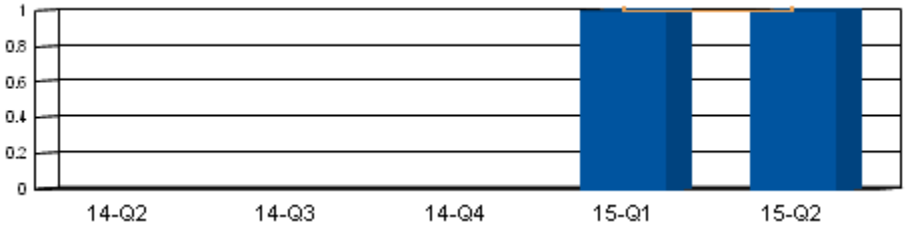
Q2 FY2015 Strategy Performance Indicators Report

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-Q2		
14-Q3		
14-Q4		
15-Q1	1	**1**
15-Q2	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. Upcoming meetings with internal and external stakeholders for feedback through engagement sessions will commence. 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 and Southeastern LHIN has occurred: now waiting for Ministry and LHIN 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 elected to report research expenses (reporting revenues based on your GAAP financial statements) as opposed to actual revenues received. 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 all 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 second 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. 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 all the nine clinicians scientists recruited to KGH through the SEAMO Clinician Scientists Recruitment Program.

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.

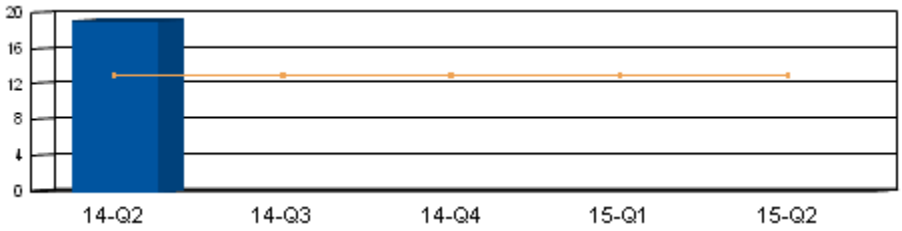
Target: Target 14/15:As per stated project milestones Perf. Corriodors: Red 0 Yellow N/A Green 1(1 = Yes 0 = No)

Q2 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-Q2	19.04	**12.9**
14-Q3		**12.9**
14-Q4		**12.9**
15-Q1		**12.9**
15-Q2		**12.9**

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

The Healthlinks project is ongoing with respect to data analysis and an understanding of patient flow. Efforts are aimed at reducing readmissions and ED visits through the provision of enhances community based services. A recent Pharmacist-led project identified opportunity for improvement in the completeness of information transfer via the eDischarge summary for patients discharged from hospital on community-based intravenous antimicrobial therapy. Deficiencies in communication and care plan establishment at this transition may lead to unplanned readmissions, Emergency or Urgent Care, or outpatient clinic visits early in the post-discharge period.

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

Current performance is well above target, however it is worth noting that this performance dates back to Q2 of last fiscal year. This readmission rate calculation takes into account readmissions to any hospital, not just the KGH and therefore we cannot replicate this calculation and must wait until it is provided by MoH. Unfortunately it is not clear what our current performance is.

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 very unlikely that we will meet this target by year end.

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

This indicator is calculated by the MOH and supplied to KGH via the Ministry LHIN Performance agreement (MLPA – a performance agreement that focuses on system performance and financial accountabilities. This indicator is best described as the number of patients readmitted to any facility for non-elective inpatient care, compared to the number of expected non-elective readmissions using data from all Ontario acute hospitals. The number of patients readmitted to any facility for non-elective inpatient care is defined as the observed number of patients, discharged with specific CMG's within calendar year, readmitted to any facility for any non-elective patient care within the specified number days of discharge for index admission.

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

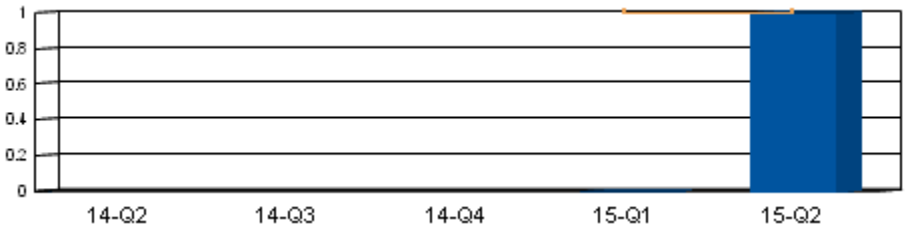
Kingston General Hospital

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

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

Began pulse surveys in selected areas to gauge progress. Incorporated elements to assess psychological risk in the questions. Expanding Peer Partner program and held meetings to review and refresh. Launched communication of health and wellness information in staff washrooms called "Living Well...Working Well." This will allow staff to be informed of health and wellness information and activities. Yoga and other fitness activities continue. Respectful workplace policy review conducted. Volunteer PDSA for service delivery improvements conducted and a revamp of orientation. Physician Departments, Residents and/or Department Heads/PMD meetings regarding the results and discussion of areas for improvement conducted.

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

Moving forward on trust and respect issues, staff education and learning strategy, health and wellness and volunteer activities. Support and check ins with leaders on departmental plan status to ensure continue to move forward. Medical Administration has already implemented a number of the recommendations increased communications and engagement on planning and decision making.

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

On track with quarterly milestone targets. Next quarter will dive deeper into recognition program, leadership development, frontline leadership and plan for mental health in the workplace. Physician Leadership Forum established and meeting quarterly.

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.

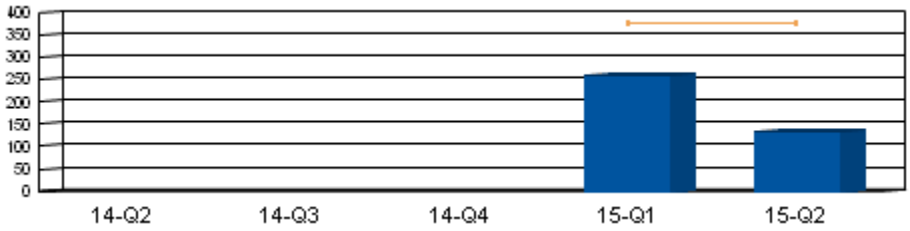
Target: Target 14/15: As per plan quarterly milestones

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

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

Targeted information sessions occurred regarding completion of performance plans. One on one touch points with leaders occurred.

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

Summer presented challenges with high vacation time impacting completion. Union performance plans are now being completed and increasing. This will impact on staff engagement, contribution and productivity.

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

Currently not at half-way target, but gaining momentum. A communication tactic plan is in place and will continue to be activated to inform and support directors, managers, and individuals about how to complete their agreements and plans.

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.

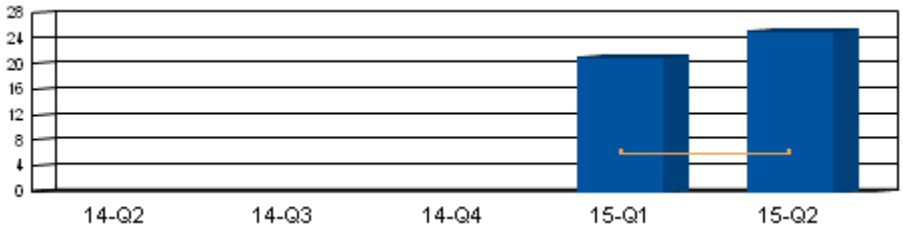
Target: Target 14/15; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375

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

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

Focused program reviews of MSI incident data undertaken in Q2 with Medicine and SPA leadership. As in Q1, Safety Advisor continues to support the investigation of all health care and lost time injury claims. OHSW has been working with Move-On project team to ensure messaging re: staff safety is included. Have made revisions to MSI patient handling training in the LMS, to integrate key messages and ensure clarity re: requirement for mobility assessments prior to every patient mobilization. Weekly reporting of MSI incidents from Safe Reporting initiated and development of quarterly dashboards including MSI metrics initiated in Q2.

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

Continue to trend high with a total of 25 claims- 22 being healthcare and 3 lost-time. Majority of claims are related to patient handling activities (72%). Highest incidence of all MSIs in SPA (36%) and Medicine (24%).

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- have already had 46 claims surpassing our annual target of 24 claims or less. With return of Ergonomist in November, will 1) meet with clinical leaders to re-initiate unit training, and 2) make plans to incorporate hands-on training with new hires, and 3) implement the patient handling LMS training.

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.

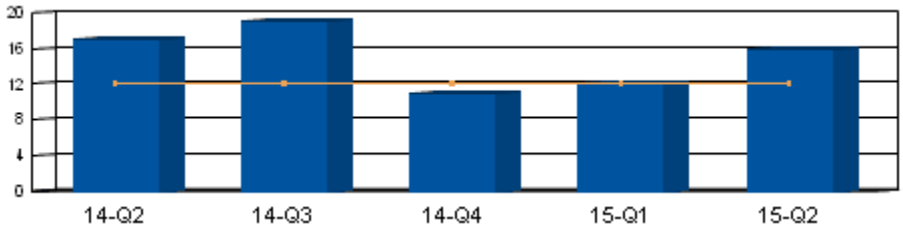
Target: Target 14/15: 6 Perf. Corridors: Red >7 Yellow 7 Green <=6

Q2 FY2015 Strategy Performance Indicators Report

People

All preventable harm to staff is eliminated

Indicator: Number of Needlestick Injuries



	Actual	Target
14-Q2	17	**12**
14-Q3	19	**12**
14-Q4	11	**12**
15-Q1	12	**12**
15-Q2	16	**12**

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

Needle Safety Training has been finalized in the LMS and is set to be launched end of October.
Conversion from Insulin needles to pens to be implemented Nov. 17th; super user and front line staff training scheduled for late Oct/early Nov. Weekly NSI reporting to Program Managers via Safe Reporting initiated and quarterly dashboards including NSI data developed and rolled out.

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

62% of this quarter's NSIs occurred in the month of July. Majority occurred in Medicine (31%) and Critical Care (25%) and over half of our NSIs occurred due to failure to properly activate the safety mechanism. 25% of our NSIs involved insulin needles.

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

Will be contingent on 1) timing of the insulin conversion (4 NSIs this quarter involved insulin needles) and 2) completion of LMS training by clinical staff, and 3) reinforcing safe needle practices with staff at the unit level as an outcome of the investigation of a NSI.

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

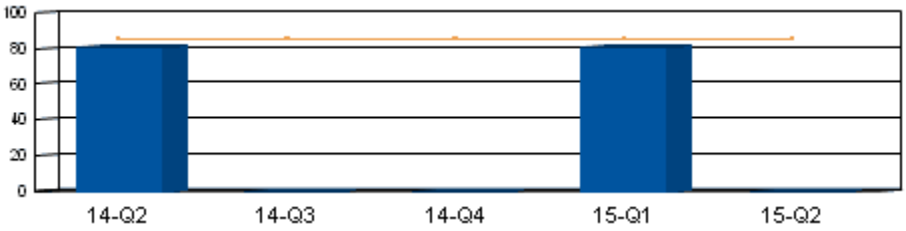
Target: Target 14/15: <=48(12/qtr.) Perf. Corridor: Red >=15 Yellow 13-14 Green<=12

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

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

This indicator is a result of independent cleaning audits by the third party company Westech. These external audits are performed semi-annually. Environmental Services Management are certified and utilize the same tools as the Westech Auditors to conduct monthly internal audits and follow-up with staff in areas that did not receive a minimum of a 85% target. The August internal audits were 86.18%. Redesigns of services have created two specific teams; one to focus on cleaning upon a patient discharge and the other to provide the daily cleaning functions. These changes are designed to improve cleaning quality. There has been no Westech Audit in Q2.

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

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

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

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

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

Westech System Inc. is an external company that performs cleaning audits throughout the Hospital. The audit categorizes the many areas of the hospital into four (4) risk categories. Patient rooms are considered Risk 2 (High risk). The audit provides detailed areas for improvement to focus education and training required for staff and management.

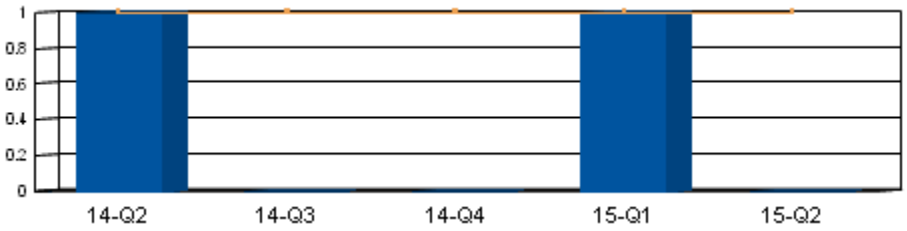
Target: Target 2012/13: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%,Target 2014/15: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

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

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

In Quarter 2 management reached out to Ministry to assess the progress of the project file in the Ministry process since completion of the filing in Quarter 1. It was confirmed that the KGH Phase 2 submission file is still under review. Additional information was provided to the Ministry on the current Operating Room challenges encountered with OR H and a visit was arranged for the new Deputy Minister to visit KGH early in Quarter 3. Similarly visits were arranged for our new local MPP and other key Ministry staff to provide these individuals with an opportunity to see the site and ask any questions they may have about our submission.

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 at the end of Quarter 2 no change in status of approval. The file is still under review in the Ministry Capital Branch and we understand the Ministry process for reviewing redevelopment files is being redesigned by the new government since their election in the Spring.

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 our expectation that we will still hear the outcome of the Ministry review before the end of the fiscal year. During this time we are waiting for a response from the Ministry we continue to try and educate the Ministry decision makers and government as to the needs to KGH and the importance of redevelopment to our communities. Tours of the site for Ministry and local political leaders are planned for Quarter 3.

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.

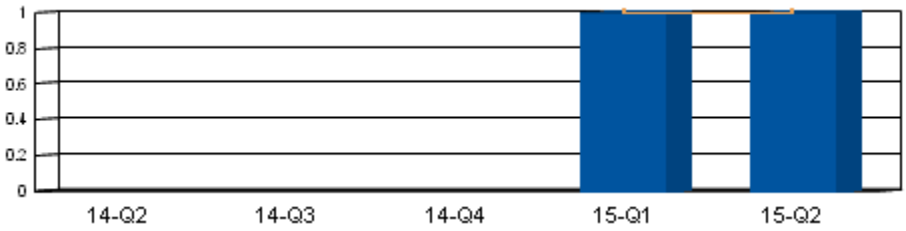
Target: Target 13/14 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes,Target 14/15 (1/0 = Yes/No) Perf. Corridor: Red 0 Yellow N/A Green 1(1 = Yes 0 = No)

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

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

KGH staff and physicians have reviewed clinical, non-clinical and technical HIS requirements internally and with the region. On September 18th, Healthtech hosted a session with the partner sites to validate these requirements using clinical scenarios. Awaiting feedback from consultants on next steps of RFP roll-out.

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 consultants anticipating that the RFP will be assembled and ready by the end of Q3.

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

Yes. Plans for next quarter are to sign off on all requirements, take part in RFP scoring discussions and finalize RFP for approval.

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

Target: Target 14/15: As per implementation schedule

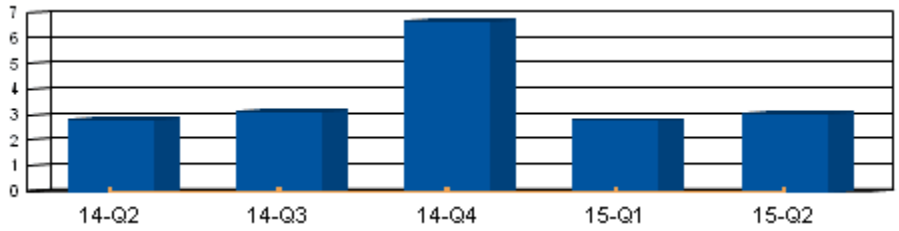
Kingston General Hospital

Q2 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-Q2	2.78	**0**
14-Q3	3.09	**0**
14-Q4	6.67	**0**
15-Q1	2.77	**0**
15-Q2	3.08	**0**

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

Monthly financial reporting and analysis were provided to those with budget responsibility. High-level summary results by category were also provided to the KGH senior leadership team for review. Essentially all identified operational efficiencies incorporated in the approved budget have been actioned.

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

The total margin as at September 30, 2014 was 3.08%. The total fiscal results were just slightly favourable to plan at the end of the second quarter by $42 thousand. While the hospital has significant clinical pressures in several areas including: emergency department, medicine inpatient units; staff vacancies and one-time revenue opportunities have offset the unfavourable fiscal impacts of higher than expected activity in the first 6 months of the year. Announced Health System Funding Reform impacts for the year were received in September and have been included in these financial results.

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

Monitoring of results and corrective actions will need to continue to ensure that year-end targeted balanced financial position is met as activity levels are not anticipated to drop in the second half of the year. Volumes in excess of the funded Quality Based Procedure (QBP) targets could put the hospital at most risk of cost overruns. As this QBP funding is tied to urgent/emergency procedures there is little ability for the hospital to control this issue but it will be monitored and managed by the respective areas of the hospital.

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).

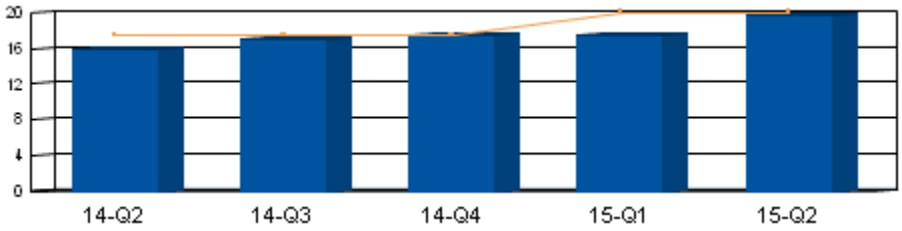
Target: Baseline 08/09: (3.9%), Target 09/10: (4.0), Target 10/11: (2.17), Target 11/12: 0, Target 12/13: 0, Target 13/14: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0, Target 14/15: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

Q2 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 Dollars for Capital Equipment, Technology and Infrastructure ($000's)



	Actual	Target
14-Q2	15.9	**18**
14-Q3	17.1	**18**
14-Q4	17.5	**18**
15-Q1	17.5	**20**
15-Q2	19.7	**20**

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

There were no Identified operational efficiencies during the quarter to facilitate moving further towards the annual $20 million target for capacity for investment in capital.

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

The capital investment capacity currently totals $19.7 million. The increase from the Q2 position is related to the increase in funding from the Ministry of Health and Long-Term Care Health Infrastructure Renewal Program (HIRF). This increased investment must be utilized to support the replacement/upgrade of building infrastructure.

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 remaining $300 thousand shortfall could be addressed with increased financial support from the KGH Auxiliary and/or University Hospital's Kingston Foundation. Current capital expenditure request listings have been provided to both organizations for funding consideration.

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

Q2 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