fiscal
2014-2015 **Q4**
4th quarter ended March 31, 2015

KGH this quarter


# Strategy Performance Report

Kingston General Hospital
*Outstanding care, always*

# KGH Strategy Performance Report Fiscal 2015 Q1



## Strategic Direction 1

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

### Outcome 1:

**Patients are engaged in all aspects of our quality, safety, and Service improvement initiatives**

**Strategic Performance Indicators**



### Outcome 2:

**All preventable harm to patients is eliminated**

**Strategic Performance Indicators**



### Outcome 3:

**All preventable delays in the patient journey to, within, and from KGH are Eliminated**

**Strategic Performance Indicators**

# 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

**Cultivate patient oriented research**

**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

# Q4 FY2015 Strategy Performance Indicators Report

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



2015/05/29 12:55:01

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

Indicates improving performance to target over the past 5 quarters ↑

Indicates worsening performance to target over the past 5 quarters ↓

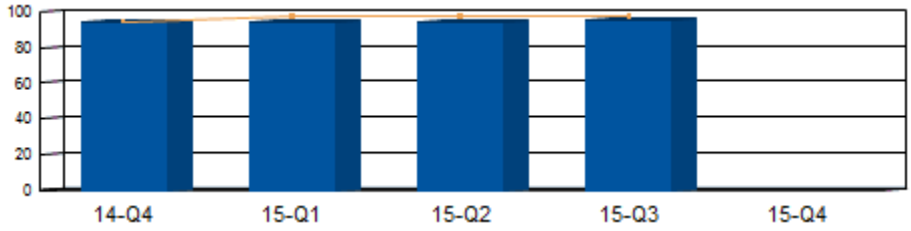
| | Strategy | | | | | QIP | | | | | Supporting | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 % | Q2 % | Q3 % | Q4 % | Q4 # | Q1 % | Q2 % | Q3 % | Q4 % | Q4 # | Q1 % | Q2 % | Q3 % | Q4 % | Q4 # |
| R | 30% | 52% | 44% | 41% | 11 | 33% | 67% | 67% | 58% | 7 | 28% | 33% | 31% | 33% | 27 |
| G Y | 33% | 48% | 56% | 59% | 16 | 67% | 33% | 33% | 42% | 5 | 65% | 66% | 69% | 67% | 56 |
| N/A | 37% | 0% | 0% | 0% | 0 | 0% | 0% | 0% | 0% | 0 | 7% | 1% | 0% | 0% | 0 |
| | | | | | 27 | | | | | 12 | | | | | 83 |

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

**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 March 31st, 2015, 866 staff, learners and volunteers have completed the Communicate with HEART training. This represents 173% of the corporate target for F14/15. 539 of the attendees required backfill. In applying a PDSA cycle to the training program at the end of Q3 in-class training time was reduced from 4 hours to 2.5 hours. This allowed us to exceed the target while staying within the allotted budget for the year.

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

There is a stretch goal for improving the overall patient satisfaction by 2%. We have targeted the training program to the medicine program with the hope of having significant impact on patient satisfaction within that group. We believe we are on target to achieve this target by year end. The Q2 data is the most recent.

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

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

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

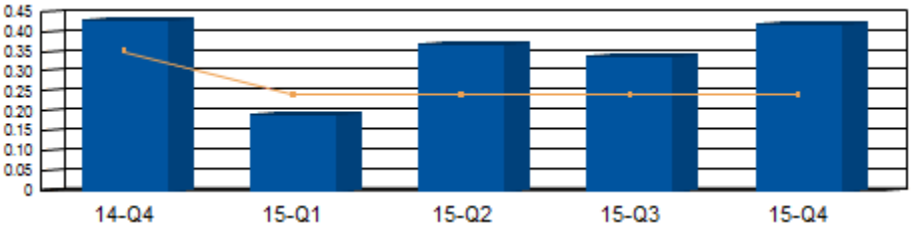
Kingston General Hospital

# Q4 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-Q4** | 0.43 | **0.35** |
| **15-Q1** | 0.19 | **0.24** |
| **15-Q2** | 0.37 | **0.24** |
| **15-Q3** | 0.34 | **0.24** |
| **15-Q4** | 0.42 | **0.24** |

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

Efforts to sustain this improving trend included: ICP presence on the units and in ED every day, working collaboratively with each of the Programs to ensure prompt initiation of "Contact Precautions" for any patient with diarrhea and obtaining a specimen for testing; ASP pharmacists ongoing assessments of orders and promotion of the CDI order set with SOPs; ongoing collaboration with the Laboratory and ensuring the appropriate use of spermicidal cleaners by Environmental Services to reduce the environmental load of spores.

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

The KGH incidence rate for the fourth quarter was 0.42 cases per 1000 patient days; a modest increase from the third quarter. In January we had 6 cases of CDI. In February we had 7 cases and in March there were 3 cases giving us a total of 16 cases. Overall for 2014 - 2015, we had 50 cases of CDI. In comparison in 2013 - 2014 we had 77 cases and in 2012 - 2013 we had 88 cases. The following are CDI rates for Ontario teaching hospitals for the month of March 2015: KGH .24, LHSC .25, HHSC .48, Ottawa .47, St Michaels .39, Sunnybrook .52. It is worth noting that KGH had the lowest rate in the month of March.

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

Although our target was not met, we continue a steady downward trend in the number of CDI cases acquired nosocomial which has been sustained for > 3 years and are now 35 months without a CDI outbreak. We had 27 fewer patients develop a nosocomial CDI this year, than last and 38 fewer than the year before.
Tactics for 2015 - 2016 including ensuring the sustainability of the close collaboration between Programs and IPAC in identification and management of both suspect and confirmed cases of CDI; increasing awareness of the CDI Order Set and SOP's; and working with ES on daily cleaning or terminal cleaning procedures for patient's environment, equipment and bathroom.

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

Clostridium difficile is a spore-forming bacterium that may be present in the environment and can colonize the intestinal tract in up to five per cent of adults in the community without causing symptoms. It can cause an infectious diarrhea in both community and health care settings. It is the single most common cause of antibiotic-associated diarrhea (AAD) accounting for 15-25% of all episodes.
All Ontario hospitals are required to report to the MOHLTC and publicly on the rates and the number of new nosocomial CDI cases associated with the reporting facility.
The CDI count is the number of new nosocomial cases of CDI by month.
The rate of CDI is calculated as follows: The number of new nosocomial cases of CDI associated with the reporting facility multiplied by 1000, then divided by the number of patient days. This rate represents the incidence rate of nosocomial CDI associated with the reporting facility per 1000 patient days.

**Target:** Fiscal 2011/12 - QIP Goal = 0.30, QIP Target for Compensation = 0.77 Fiscal 2012/13: 0.3, Target 13/14: 0.37 Perf. Corridor: Red >0.42 Yellow 0.38-0.41 Green <=0.37, Target 14/15: 0.24 Perf. Corridor: Red >0.26 Yellow 0.25-0.26 Green <=0.24

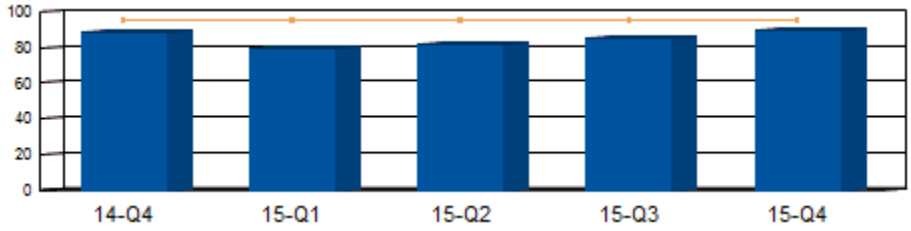
Kingston General Hospital

# Q4 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: Hand Hygiene Compliance - (QIP)




| | Actual | Target |
|---|---|---|
| **14-Q4** | 88.2 | **95** |
| **15-Q1** | 79.7 | **95** |
| **15-Q2** | 82.0 | **95** |
| **15-Q3** | 85.0 | **95** |
| **15-Q4** | 89.4 | **95** |

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

Significant efforts within Programs this year to improve the number of audits being conducted and observed opportunities resulted in increases to the denominator each quarter. The Hand Hygiene Working Group continued to meet to develop new strategies to improve compliance rates. A new Resource Tool provides clear guidance on what is Patient Environment vs. what is Hospital Environment. In addition, support for increasing the role of the auditor from being an observer only, to providing "Just in Time" education has been developed and is rolling out.

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

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

Overall corporate HH rate for this quarter was 89.4%. The before moment for Quarter 4 was 87.5%, an increase from Quarter 3's 85%; the after moment was 92.3% also an increase from Quarter 3's 90%. These rates are the reflection of 4,304 observed opportunities. Total opportunities for 2014 - 2015 were 18,037, a significant increase from 2013 - 2014 when our total opportunities were 11, 257. There was also an important increase in the number of HCW observed, in 2014 - 2015, 14,048 HCW were audited; in 2013 - 2014 there were 7,801 HCW audited. The increase of 6,780 HCW observed provides a broader representation of staff.

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

The target of 95% was not met this year. Efforts within the Programs and from IPAC Service to support auditors resulted in the roll out of a training manual for all new auditors, and ongoing support for trouble-shooting with devices resulted in the number of observed opportunities significantly increased. The further roll out of the new Resource Tool and the "Just in Time" intervention training and education supported by The Hand Hygiene Working Group (HHWG) will contribute to further improving compliance rates and optimize patient's safety by reducing opportunities for the transmission of organisms via healthcare workers hands. In addition, the HHWG has begun discussions on another new initiative that will target education on the appropriate usage of gloves.

**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%

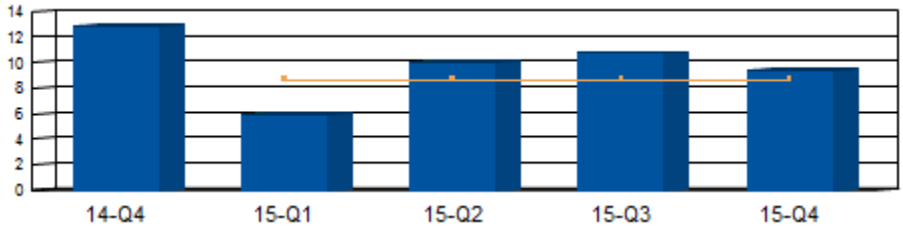
Kingston General Hospital

# Q4 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-Q4** | 12.90 | |
| **15-Q1** | 5.90 | **8.68** |
| **15-Q2** | 10.07 | **8.68** |
| **15-Q3** | 10.74 | **8.68** |
| **15-Q4** | 9.40 | **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 Q4 rate is greater than the provincial target. Mortality reviews have not found issues/concerns with care or process. There were 8 deaths in Q4.

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

No, however it is important to note that everyone one of these deaths is subject to a mortality review by the relevant surgical service. This process will continue for fiscal 15/16 an indicators will become a supporting indicator.

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

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

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

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

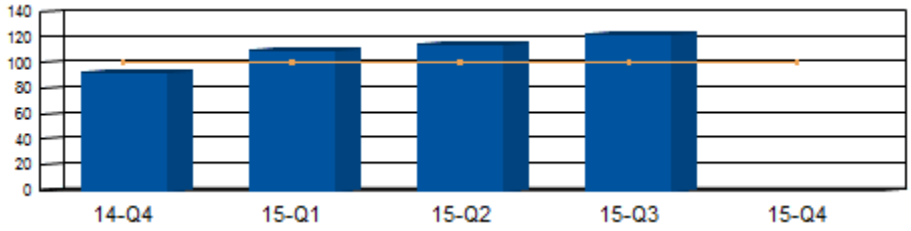
Kingston General Hospital

# Q4 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: Hospital Standardized Mortality Ratio (HSMR) (QIP)




| | Actual | Target |
|---|---|---|
| **14-Q4** | 93 | **100** |
| **15-Q1** | 109 | **100** |
| **15-Q2** | 115 | **100** |
| **15-Q3** | 122 | **100** |
| **15-Q4** | | **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:**

CIHI has just released the Q2 and Q3 data for this fiscal year. The HSMR data set was recently readjusted to a new baseline. HSMR data is no longer compared to 100. Instead, HSMRs are compared with the current national HSMR. Quarterly morality reviews are on-going by the clinical departments. No concerns or trends have been reported to the MAC's Joint Quality and Utilization Committee. The 5-day post major surgical death reviews have also not identified any concerns regarding quality of care. There were 44 palliative deaths (10%) included in the data calculations. Inclusion of palliative deaths because of coding protocols at CIHI continues to be a difficulty in analysis. A coding review with respect to the capture and accuracy of comorbidities is planned. There is concern this is under-represented/documented in the chart.

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

No. The HSMR data will be reviewed to reassess trending within the medical/surgical groups to see were the current increase in HSMR may have increased.

**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.

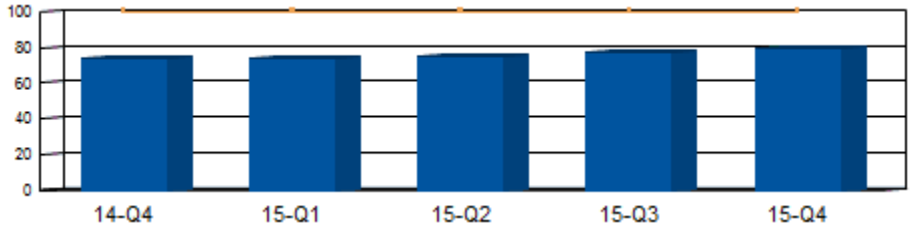
**Target:** Baseline 08/09: 111 , Target 09/10: 100, Target 10/11: 100, Target 11/12: 106. Target 12/13: 100, Target 13/14: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant, Target 14/15: 100 Perf. Corridor: Red Statistically Significant Results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

# Q4 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-Q4** | 74 | **100** |
| **15-Q1** | 74 | **100** |
| **15-Q2** | 75 | **100** |
| **15-Q3** | 77 | **100** |
| **15-Q4** | 79 | **100** |

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

A standard Surgery Admission Order Set embedding the medication reconciliation process endorsed by the Executive Committee of the Division of Surgery and the Surgical Program Council was approved by the Order Set Committee and distributed to all areas of the hospital where admission orders for surgical patients are written in March 2015.

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

The percentage of patients who receive medication reconciliation at the time of admission to the Hospital has increased from 77% in F15 Q3 to 79% in F15 Q4, a slow but steady and constant increase since implementation of this indicator in F14 Q1 (65%).

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

With the implementation of the surgery admission order set in March 2015, the total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital should exceed 80% in F16 Q1. A one month post-implementation audit showed 50% compliance. Medication reconciliation is now a component of the post-operative surgical safety checklist. The F16 KGH tactics include prescriber engagement and education. Implementation of EntryPoint in the surgical program is also planned for F16 which will improve prescriber access to the admission orders. KGH is partnering with HDH to review the documentation of home medications for elective surgical patients in the pre-surgical clinics at HDH..

**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.

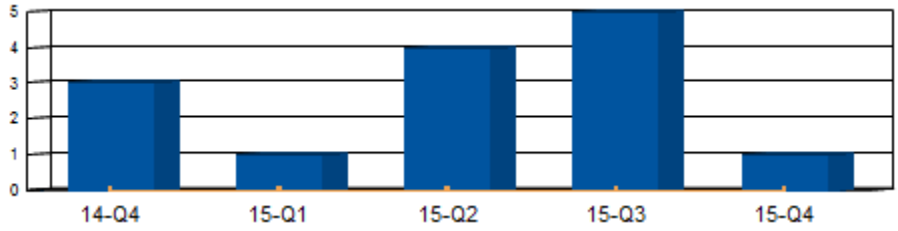
**Target:** Target 14/15: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

# Q4 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: Achieve Zero Patient Falls in Level 3 and Level 4 Categories - (QIP)




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

One level 3 fall occurred in the fourth quarter & zero level 4. This fall was reviewed at the Program level to identify causal factors that can be used to support improvements. The fall involved an ambulating patient. After review the it was determined that the appropriate levels of supports were in place. There were no specific gaps in the safeguards identified.

**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 did not deliver zero level 3 or 4 falls within the fiscal year. All improvement cycles were completed. We will develop further improvements, risk identification and screening standards for the coming year. Significant other achievements are the procurement and installation of over 100 new beds through the hospital, all of which are now in place and aid in alerting care teams of patient movement (bed alarms) and enable reduced fall heights. It is of note that this completes year one of a three year bed replacement plan.

**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

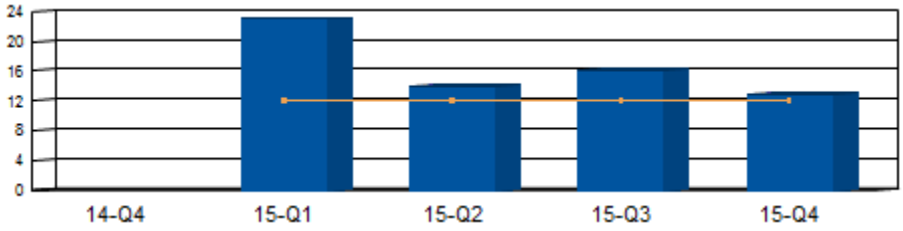
Kingston General Hospital

# Q4 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 Incidents Associated with Morphine or Hydromorphone




| | Actual | Target |
|---|---|---|
| **14-Q4** | | |
| **15-Q1** | 23 | **12** |
| **15-Q2** | 14 | **12** |
| **15-Q3** | 16 | **12** |
| **15-Q4** | 13 | **12** |

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

A morphine and hydromorphone nursing education program was implemented in March 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:**

A 50% reduction in the incidence of hydromorphone and morphine medication administration incidents through the implementation of automated dispensing cabinet alerts and mandatory nursing education was achieved in F15 Q4.

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

The Hospital did not meet target of 48 reported administration incidents by end of Fiscal year as 66 incidents were reported throughout Fiscal 15. An automated dispensing cabinet alert implemented in November 2014 and a nursing education program implemented in March 2015 supported the Hospital to meet the quarterly target of 12 incidents in F15 Q4 (actual incidents: 13). Thirty eight percent of nurses (503 out of 1324) have completed the education module as of May 10, 2015. The number of incidents involving hydromorphone being administered in place of morphine has decreased by 50%.

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

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

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

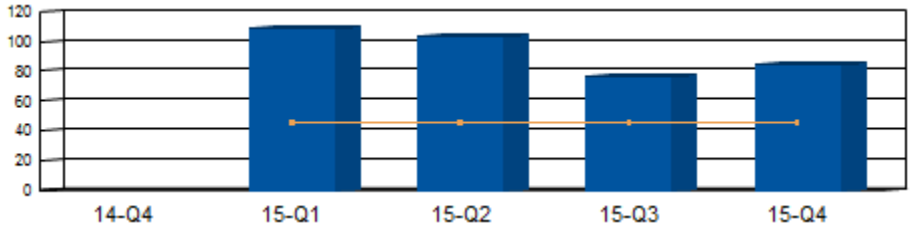
Kingston General Hospital

# Q4 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-Q4** | | |
| **15-Q1** | 109 | **45** |
| **15-Q2** | 104 | **45** |
| **15-Q3** | 76 | **45** |
| **15-Q4** | 84 | **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. Results overall this past year continue to trend and are heading in the right direction. This specifically can be seen in the Emergency and Critical Care areas. Preparing for next fiscal more focus will be placed on stakeholder engagement which will include standard work processes, education and tools to do the job.

**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 collection errors have been identified as one of the top three sources of preventable harm to patients at KGH. Specimen collection for laboratory testing is a critical part of a patient's journey since the lab tests will determine the course of action for the patient. Medical decisions can include diagnosis, prognosis, risk and predictive assessment, prevention and screening and the monitoring of treatment and therapy.

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

The target of 45 specimen collections per quarter was not reached. However, it needs to be noted that in some areas a significant reduction was made. In other areas there were more one-off errors which drove the overall number of errors up. The phlebotomy service will continue to be expanded, working closely with the Patient Relation Quality Advisors (PRQAs) and front line staff and targeted units where value stream mapping will be completed to help identify any gaps in knowledge or process. Key learning's can then be applied to other areas.

**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 mislabelled specimens sent to the clinical laboratory.

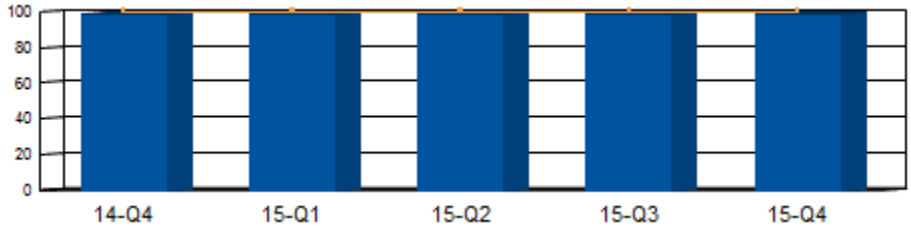
**Target:** Target 2014/15: 45 Perf. Corridors: Red >75 Yellow 56-75 Green <=55

# Q4 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-Q4** | 99 | **100** |
| **15-Q1** | 99 | **100** |
| **15-Q2** | 99 | **100** |
| **15-Q3** | 99 | **100** |
| **15-Q4** | 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 continue to assist in the sustainability of meeting this target. In the 4th quarter an adjustment to the current electronic system to add mandatory screens will assist in future of ongoing success of meeting this quality and safety metric.

**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 Q4 YTD, this indicator continues to meet the green target corridor. There were 9,125 patients who received surgery at KGH this year. The OR team's compliance for the Surgical Safety checklist 3 phases overall were the following: Briefing- 99.5 %, Timeout-99.2%, and Debrief- 99.6%.

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

Target continues to be in the green range.

**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.

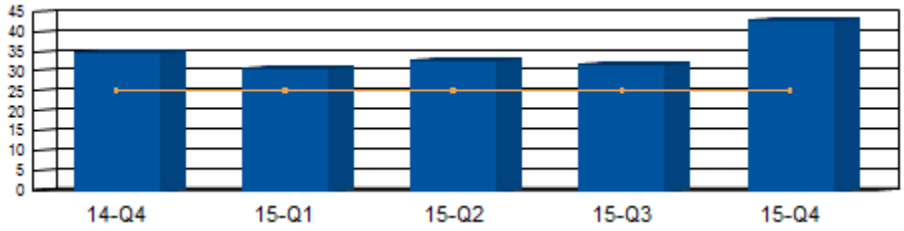
**Target:** Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%

# Q4 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-Q4** | 35.0 | **25** |
| **15-Q1** | 30.7 | **25** |
| **15-Q2** | 32.6 | **25** |
| **15-Q3** | 31.6 | **25** |
| **15-Q4** | 42.7 | **25** |

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

GOOG (Get out of Gridlock) was implemented on February 9th with the goal of getting out of gridlock by March 31. KGH had been in Gridlock since October 23, 2014. The GOOG project focused on implementing individual improvement cycles developed as a result of opportunities identified in the VSM in May 2013, simultaneously. Gridlock indicators were used as a measure of success - defined as 2 of 3 indicators in green. 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. The new bed map was implemented on January 26.

**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 Q4 result of 42.7 hours is 17.7 hours longer than the 25 hour target. Twenty percent of all patients admitted through the ED waited 42.7 hours or longer to be transferred to an inpatient bed. Based on Q4 admission volumes of 2676, 268 patients waited 42.7 hours or longer in the ED for an inpatient bed. Of note, the performance in January was particularly high at 49.8 hours at the 90th percentile. Inpatient days in the ED are 1243 this quarter which is the equivalent of 14 beds. This has a negative impact on the ability to see, assess and treat other patients within the recommended time and poses a risk for patients in the waiting room for long periods of time. Patients in the ED for this length of time are in the wrong place to receive optimum care. Providers in the ED are forced to work in a fraction of the department to care for the sickest patients. LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning. Our performance is different from our peers this quarter with each of the following hospitals seeing an improvement in Q4 over Q3. Our result of 42.7 is the highest amongst our peers. LHSC = 35.6, HHSC = 30.9, SMH = 23.6, SHSC = 31.6, TOH = 30.5, TBRHC = 38.6

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

No. The target for this year was not met. The target is not a reasonable target and the SE LHIN has acknowledged this and changed the target to 29 hours in 15/16.

**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.

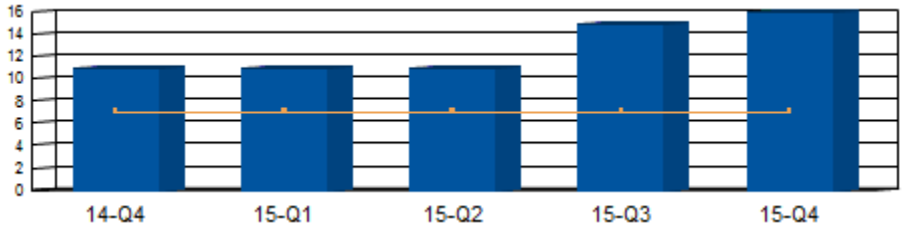
**Target:** Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28

# Q4 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-Q4** | 11.0 | **7** |
| **15-Q1** | 11.0 | **7** |
| **15-Q2** | 11.0 | **7** |
| **15-Q3** | 14.8 | **7** |
| **15-Q4** | 16.0 | **7** |

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

KGH and regional partners have committed to a renewed focus on ALC and as a result, a number of initiatives are underway. Within KGH, steps that are being taken include:
o A registered nurse has been seconded to be the KGH point of contact for ALC patients.
o A 'tiger team' meets weekly to look at the current status of ALC patients at KGH, to review & revise any processes and to advise on steps to support consistent adoption of ALC designation processes. The Tiger Team is aligning it's effort to the work happening on a LHIN-wide basis to ensure standardization to the degree possible. Policies being revised are: 1.Discharge Policy (including escalation process); 2. Emergency/Primary Care-Discharge of Non-Admitted Patients to Supportive Care Settings Policy;
3. Patient Transfer to Supportive Care Settings (Inpatients) Policy; 4. Alternate Level of Care Policy;
5. Alternate Level of Care Co-Payment Policy
o The ALC designation process is being refreshed to include the development of a message that supports exploring all options for transition of care or discharge.
o Current order set for ALC designation is being revised to introduce a new inter-disciplinary process for assessment and decision making regarding ALC for long term care.
o Working closely through a regional Peer to Peer group that is made up of representatives from all hospitals, the CCAC and SE LHIN to develop best practice approaches for managing ALC and improving key processes and policies that will support ALC patients reach their best destination in a timely way thereby reducing overall time in an acute care setting. Also the SELHIN Peer to Peer Group has been asked to make hospital site visits in the SE to bring forward recommendations to drive change and improvement based on best practices in place across the region. No visit dates have been set yet.

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

This indicator is described as the percentage of inpatient days that patients' occupying an acute care hospital bed has finished the acute phase of his/her treatment. The total number of ALC days is influenced by both the number of ALC patients and their ALC-specific lengths of stay. The F16 target is 10% ALC days compared to 7% in F15.

The Q4 result of 16% indicates that, on average, there were more than 65 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.

All partners are experiencing the same issues. Data from across the SE LHIN indicates that there are upwards of 200 ALC patients occupying an acute care bed at any one time. Depending on the total number of beds, ALC can represent between 10-60percent of total acute care beds being occupied by ALC patients. As indicated this equals 16% of ALC days at KGH in Q4.

**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 did not meet the target of 7% ALC days in F15. Despite significant efforts across hospitals and the SE CCAC, ALC rates remain high. Efforts continue in earnest to implement internal process improvements and maximize opportunities, working collaboratively with our partners across the LHIN, to support individuals in need get to the most appropriate destination once they have completed the acute phase of their journey. As we know, this is a system issue requiring system solutions. There is strong commitment throughout KGH to reduce ALC rate moving closer to the QIP target in F16. The target for F16 has been changed to 10%.

**Definition:** DATA: Decision Support COMMENTS: Cynthia Phillips STRATEGY REPORT

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

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

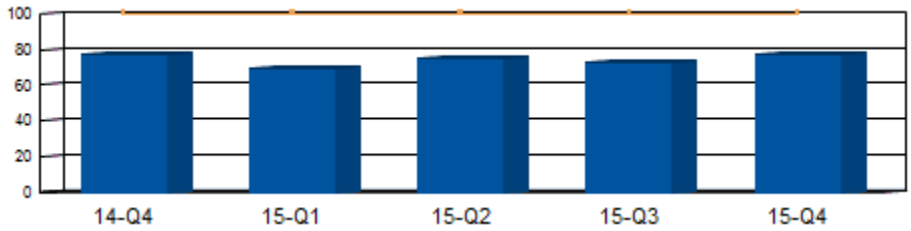
Kingston General Hospital

# Q4 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-Q4** | 77 | **100** |
| **15-Q1** | 69 | **100** |
| **15-Q2** | 75 | **100** |
| **15-Q3** | 73 | **100** |
| **15-Q4** | 77 | **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 an increase in the number of services meeting the 90th percentile wait time target in Q4. Only 12 of 52 clinical areas have a status of Red with respect to meeting their wait time targets: 1 general surgery; 1 gyn, 1 neurosurgery, 4 orthopedic; 3 plastics, 1 urology, and 1 DI (MRI). The Wait Time Committee continues to review the current change and focus on sustainability of initiatives that lead to the improvements in wait times.

**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 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. For fiscal 15/16, an evaluation of the roles of the Wait Times Committee and the QBP Steering Committee will be reviewed in Q1 with a goal of combining the two roles into a single committee that will be action focused on access to care.

**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%

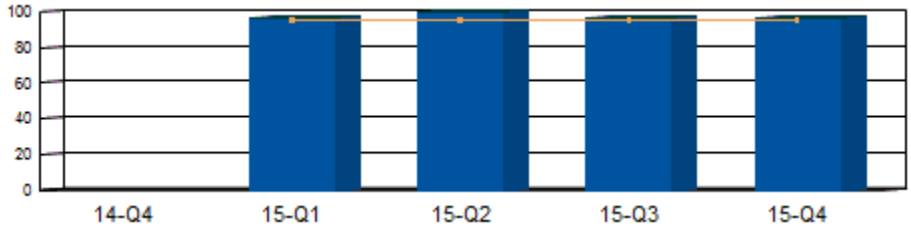
Kingston General Hospital

# Q4 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-Q4** | | |
| **15-Q1** | 96 | **95** |
| **15-Q2** | 100 | **95** |
| **15-Q3** | 96 | **95** |
| **15-Q4** | 96 | **95** |

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

Occupancy/utilization and ALC data is reported to programs and at a corporate level for awareness, and is shared with the LHIN during quarterly reviews in light of system influences and impacts. Recognizing the importance of timely access to KGH's beds to meet acute care needs in the region, much attention is being placed on achieving a 95% occupancy target.

Considerable effort has been made to reduce length of stay however; the growing number of ALC patients occupying acute care beds along with increase in the number of admissions from Emergency are adding pressure for bed access and driving up the occupancy rate. Bed map redesign was fully implemented in January 2015, bringing 14 temporary beds on Connell 3 on line with permanent status. An ALC Task Team, formed in Q3, has the mandate to focus on appropriate ALC designation and facilitating discharge through education, policy change and process improvement. Early results from this team are showing positive results, lowering the ALC number at KGH. The hospital remains transparent with regional partners and the LHIN on ALC and Gridlock status. ALC is identified as a SECHEF priority and will be integrated into future system design through the Health Care Tomorrow initiative. KGH is working with their teams and our partners on the initiatives related to behavioral support in community as well as ALC flow.

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

The Q4 overall medical/surgical occupancy rate of 96% exceeds the target of 95%. It's important to note that a data error inflated the occupancy rate in Q3 so the corrected number was 96% at the end of Q3 as well. Hence, KGH's occupancy rate has not changed between Q3 and Q4. Occupancy at this rate reflects the challenge with having capacity to support patient access to beds and patient flow.

As indicated in Q3, a number of factors are driving the 96% occupancy, namely 1) increase in volumes of patients being seen in the Emergency Department; 2) increase in admissions and 3) 23% increase in the number of ALC patients, from 43 in Q1 to 53 in Q4 (please note this number fluctuates and is at 57 as of April 29, 2015. ALC was 61 as of end of Q3).

There is variation between the occupancy rates of the clinical programs with Medicine consistently being above 100% (102% in Q4), and offset primarily by lower occupancy in pediatrics and obstetrics. A medicine occupancy rate of 102% translates into average use of 212 beds in Q4 compared to a funded bed complement of 210 and use of 3 overcapacity beds on average throughout the quarter. Medicine's occupancy rate improved between Q3 and Q4 due to the bed map changes which added 14 beds to the medicine complement. There remains sensitivity to the variation within programs such as SPA with higher occupancy Monday to Friday and lower occupancy on weekends.

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

We did not meet the target by year end. However we hope our focus on ALC designation and other patient flow initiatives we will see KGH's the occupancy rate trending downward toward the target of 95% in F16.

**Definition:** DATA: Decision Support COMMENTS: Silvie Crawford 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.

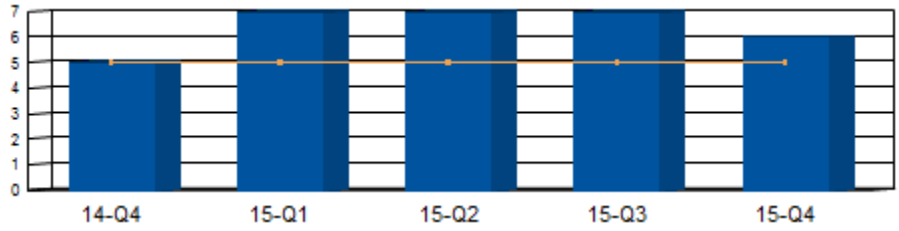
**Target:** Target 14/15: 95% Perf. Corridors: Red >=100% Yellow 96%-99% Green =95%

# Q4 FY2015 Strategy Performance Indicators Report

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

**All preventable delays in the patient journey to, within, and from KGH are eliminated**

## Indicator: OR Cancellation Rate




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

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

The OR Cancellation working group continues to monitor and evaluate strategies put in place in Q2 by the working group. Additional focus on avoidable cancellations ( patient no show, patient not prepared for surgery, patient refused surgery, surgery already done, and incorrect office bookings) is planned for the next fiscal year.

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

Our target of 5% is well within the range of our peer teaching hospitals as is our current performance. This is a reasonable target. Our peer hospitals (Q3 data only available) include:
London Health Science Center = 4.4
Hamilton Health Science Center = 9.8
St Michaels Hospital = 5.2
Sunnybrook Hospital = 5.0
Trillium General Hospital = 10.0
Ottawa = 3.7
Thunder Bay = 3.9
Sudbury = 4.2

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

The target was successfully achieved in this quarter.

**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

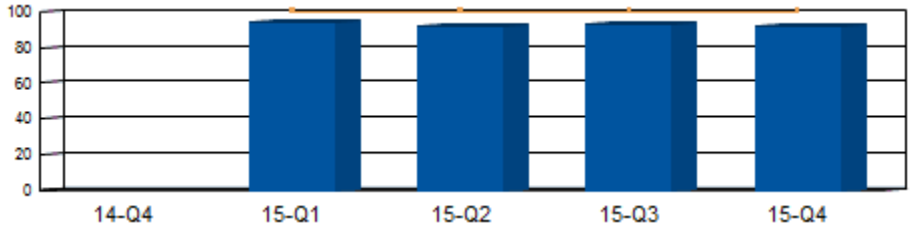
Kingston General Hospital

# Q4 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-Q4** | | |
| **15-Q1** | 94 | **100** |
| **15-Q2** | 92 | **100** |
| **15-Q3** | 93 | **100** |
| **15-Q4** | 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. Over 700 staff have completed the training. The steering group has evaluated the training and adapted it to best suit staff's learning needs.

**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 7339 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those audits 92% were in compliance. The individual standards are being reported at a corporate compliance rate of at least 92%. (Badges 92%, whiteboards 92%, Communication 96%, 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 18 with all programs having completed the 2 forums expected of them.

**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 which more than meets our target of 85% for this year. All 9 Programs have completed their expected two feedback forums.

**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 85% corporate compliance rate for each standard practice.

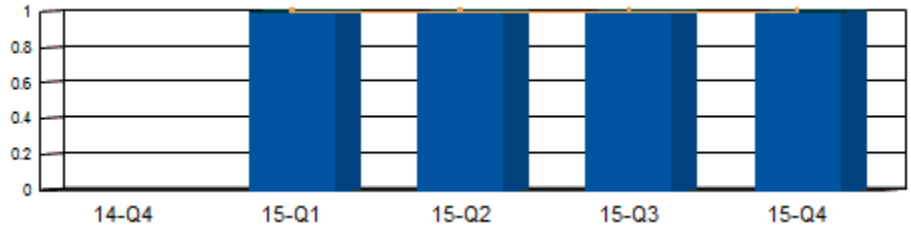
**Target:** Target 14/15: 100% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%

# Q4 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-Q4** | | |
| **15-Q1** | 1 | **1** |
| **15-Q2** | 1 | **1** |
| **15-Q3** | 1 | **1** |
| **15-Q4** | 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. Discussions with Vendor to date have revealed the importance of considering the tax structure of the new venture concurrently with determining its legal status. The partners have agreed to expand the scope of the current contract to include the financial benefits of various corporates structures with respect to Harmonized Sales Tax (HST) and the Scientific Research and Experimental Development (SR&ED) Program. Various governance models were presented to the partners for consideration. Based on stakeholder consultations, experience to date and consideration of governance issues, a unicameral reporting structure is the recommended way forward. The establishment and operationalization of the single, overarching entity for health research in Kingston will be the focus for the next fiscal which will be led by a transition team over the next 12-18 months. 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, style tiles, and wire frames for new KGHRI website completed. Content development has started. KGHRI website expected to be launched summer 2015. We have also finalized the 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: Support for renovations of Connell 4 for the W.J. Henderson Centre for Patient Oriented Research continues with UHKF raising ~$2.2 million in pledges and past donations to date: the target is $3.0 million. An additional $1.2 million from Canada Foundation for Innovation (CFI) funds from two successful grants from GIDRU and the Centre for Neuroscience Studies will also contribute to the renovation. Total cost for project ~$6M. We will build the new Centre in two phases. Phase 1 will proceed now with secured funds (~$3.5M), while phase 2 will occur once remaining funds raised and/or additional CFI grants awarded (~$2.5M). Phase 1 will see approximately 50%-60% of the floor renovated while the remaining un-renovated area will be used with minor improvements to support the Centre. Functional programmers have completed a functional & space program plan and a functional program (cost) estimate plan for the new Centre. Architects and engineers have completed a sketch design and are working on the layout for the new Centre. Pre-capital submission to both Ministry of Health & Long-Term Care (MOHLTC) and Southeastern LHIN (SELHIN) occurred in October 2014. SELHIN approval obtained on December 17, 2014. MOHLTC approval obtained on March 19, 2015 to proceed up to 3.2 (Preliminary Design Development). Anticipate going to tender towards the end of 2015 with final construction of phase 1 completed by the summer of 2016. We submitted Phase 1 and Phase 2 plans to both the SELHIN and MOHLTC: should the remaining funds be raised by UHKF and/or additional CFI grants are awarded before construction is over, we will be able to proceed with Phase 2 immediately without having to re-submit as a new proposal to the SELHIN and MOHLTC.

**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" list and Kingston General Hospital was in the list again. KGH's ranking by Research Infosource (published in November 2014) dropped from 22nd to 27th overall from prior year's standing. However, this is attributable to a change in financial reporting agreed upon by CAHO this past fall. The major difference is that CAHO members agreed to follow expense-based revenue recognition (GAAP principals), rather than to report total revenues received, as in previous years. The CAHO hospitals were the only hospitals to adopt expense based reporting. For 2015, Research Infosource is requesting participating hospital institutions to report data similar to CAHO. They are also asking institutions to go back and report data submitted in 2014 in a similar fashion. The next list will be out in November 2015 and will re-rank all hospital institutions over the past two years (2014 and 2015).

Based on the fiscal year to date, KGH met its target by the end of the fourth quarter. The Joint Venture will enhance the coordination, visibility, promotion and growth of health research, collectively and at our individual institutions. By not enhancing the coordination, visibility, promotion and growth of health research, we will run the risk of not being competitive in recruiting high quality personnel and researchers.

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

# Q4 FY2015 Strategy Performance Indicators Report

## Cultivate patient oriented research

### Externally funded research at KGH has increased by 50%

We have met our target by year end. This target indictor will be retired in F2016 along with all of the current performance indicators that we have followed over the last five years as part of the KGH 2015 Strategic Plan. We are creating new tactics and performance indicators that will support the new improvement priority "Advance the plan for a Kingston-wide health research enterprise" and our new target to "Open the William J. Henderson Centre for Patient-Oriented Research (CPOR)". Also new for next fiscal will be a change in the reporting style of the information provided to the KGH Board. We will switch to more of a story-telling/research translation exchange versus listing milestones completed. We will also focus more on the impact of our new initiatives on the delivery of care to patients and staff within the organization as research discovery today leads to treatment tomorrow.

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

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

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

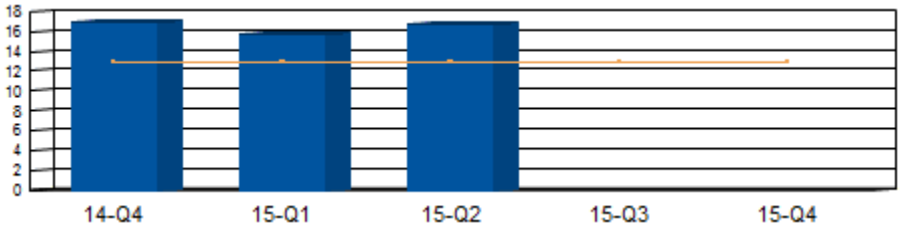
Kingston General Hospital

# Q4 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-Q4** | 17.04 | **12.9** |
| **15-Q1** | 15.80 | **12.9** |
| **15-Q2** | | **12.9** |
| **15-Q3** | | **12.9** |
| **15-Q4** | | **12.9** |

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

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

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

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

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.

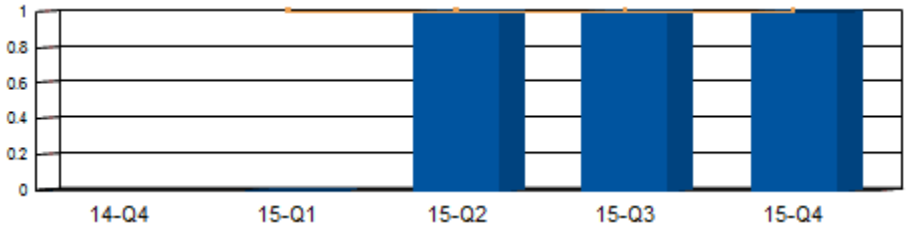
**Target:** Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%

# Q4 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-Q4** | | |
| **15-Q1** | 0 | **1** |
| **15-Q2** | 1 | **1** |
| **15-Q3** | 1 | **1** |
| **15-Q4** | 1 | **1** |

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

Engagement stories in a booth were showcased at the Interprofessional Expo. New positions were solidified in interprofessional education to support the learning redesign strategy. The LEADS capabilities framework and competency assessment was introduced and will infuse the leadership development strategy. A briefing note which reviewed recognition programs was forwarded to Planning and Performance committee for review. A focus on reducing workplace violence, psychological safety, and recommendations from risk assessments occurred. Policies were updated related to conduct and workplace respect.

**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 areas of focus on the corporate engagement plan continued under trust, education and learning, health and wellness and recognition. Other areas of focus include volunteer and physician engagement. These focus areas were driven by the previous results as having the greatest opportunities.

**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 2015 Employee and Physician Engagement Survey preparation underway for a Fall 2015 launch. A new Leadership Development Program Framework has been developed and will be launched in Q1. Further work on recognition, mental health in the workplace training and respect will continue in the upcoming year. A continuation in the next year with physician, learner and resident engagement along with volunteer engagement activities is planned. There is a new target that will focus on increasing the metric related to opportunities for education and learning in the upcoming fiscal year.

**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.

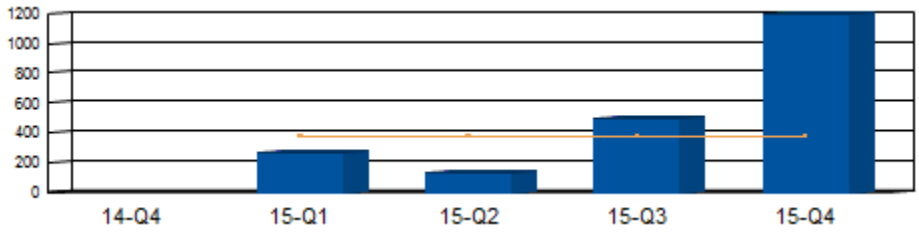
**Target:** Target 14/15: As per plan quarterly milestones

# Q4 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-Q4** | | |
| **15-Q1** | 259 | **375** |
| **15-Q2** | 132 | **375** |
| **15-Q3** | 495 | **375** |
| **15-Q4** | 1,198 | **375** |

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

The target was part of a two year commitment to ensure performance conversations were happening at the individual level. The progress was attributed to focused effort, leadership, support and link with engagement that enabled our goal to be achieved. The upcoming 2015-16 plan outlines an additional 1500 performance plans to be completed which will ensure it becomes part of our ongoing commitment to this endeavor.

**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 goal was based on feedback from staff and reinforced in our employee engagement survey. Some indicated that in 25 years of work they have never had a performance conversation. There are now more than 4000 goals declared, 2084 strengths revealed, and 65% of our employees have now had individual relationship building and engagement driving conversations.

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

This goal was based on feedback from staff and reinforced in our employee engagement survey. Some indicated that in 25 years of work they have never had a performance conversation. There are now more than 4000 goals declared, 2084 strengths revealed, and 65% of our employees have now had individual relationship building and engagement driving conversations.

**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.

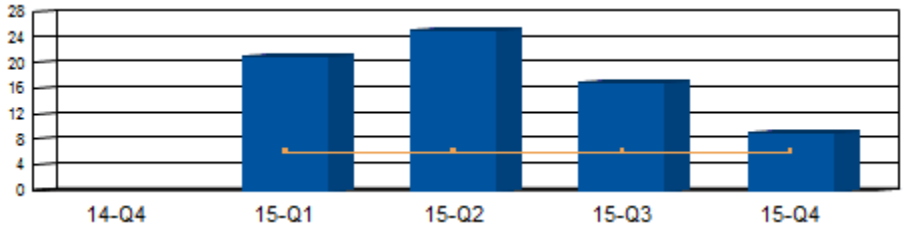
**Target:** Target 14/15; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375

# Q4 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-Q4** | | |
| **15-Q1** | 21 | **6** |
| **15-Q2** | 25 | **6** |
| **15-Q3** | 17 | **6** |
| **15-Q4** | 9 | **6** |

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

Safe Patient Handling Training via the LMS was rolled out at end of Q4 with a focus on assessing patient mobility. General MSI prevention training for all non-clinical staff has been completed and will be rolled out early in Q1. Information discouraging use of the KGH ER Department for first aid was sent out to all units and may have had a positive impact on this quarter's incidence of WSIB claims. 150 new beds with bed alarms and high-low capability received in March.

**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 had the lowest incidence this year, about half that seen in other quarters. Of the 9 MSI related health care claims, 2 were a result of patient handling with 7 due to all other causes. Through the provision of modified work this quarter to 17 additional workers who had sustained a work-related MSI, lost time injuries were avoided.

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

Tactics focused on preventing MSIs that occur during patient handling/mobilization is the focus in 2015-16. In-services on the inpatient units will continue and an assessment of capital equipment needs will be undertaken. Over 100 additional beds approved for purchase and ordered in April/15.

**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.

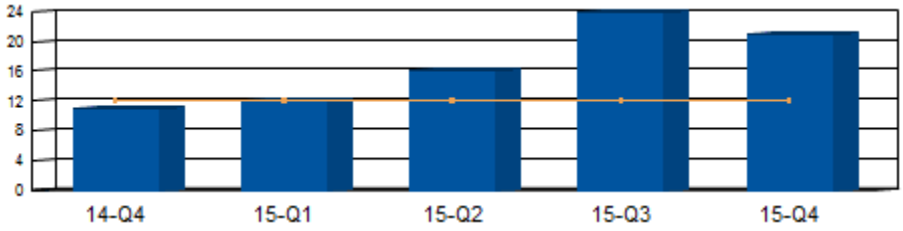
**Target:** Target 14/15: 6 Perf. Corridors: Red >7 Yellow 7 Green <=6

# Q4 FY2015 Strategy Performance Indicators Report

## People

### All preventable harm to staff is eliminated

**Indicator: Number of Needlestick Injuries**




| | Actual | Target |
|---|---|---|
| **14-Q4** | 11 | **12** |
| **15-Q1** | 12 | **12** |
| **15-Q2** | 16 | **12** |
| **15-Q3** | 24 | **12** |
| **15-Q4** | 21 | **12** |

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

Conversion from insulin needle to insulin pen occurred late in Q3 with no insulin pen needlesticks in Q4. Needle safety training implemented late in Q3 with completion rate among clinical staff at 67% as of end of Q4. In addition to training reinforcing the process and importance of reporting needkestick injuries, there has been a focus on encouraging reporting among medical residents.

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

25% of our needlestick injuries involved a suture needle. In terms of how the injury occurred, 33% involved improper activation of the safety mechanism or failure to activate it. Annual target was 48 or less and actual total reported incidence was 74. Improved reporting may be a factor contributing to the apparent increase.

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

Completion of needle safety training, investigation of needlestick injuries with identification and correction of root cause(s) will be the focus for 2015-16. In order to improve our understanding of needles involved in injury, the device list in Safe Reporting has been revised for 2015-16. OR is training medical students on safe instrument handling in June and this will include suturing; Resident training on suturing also being planned by the OR.

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

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

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

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

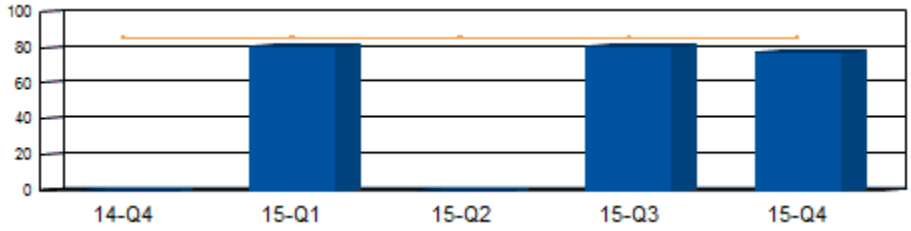
Kingston General Hospital

# Q4 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-Q4** | 0 | **85** |
| **15-Q1** | 81 | **85** |
| **15-Q2** | 0 | **85** |
| **15-Q3** | 81 | **85** |
| **15-Q4** | 77 | **85** |

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

Work observation and increased in-house audits were implemented at the end of the quarter subsequent to receiving the March Audit report.

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

An increase in percentage of failure rates for doors, vents/register, baseboards and sink/tub/showers due to dust accumulation.
Average scores decreased in some high risk areas as follows

| Area Description | Oct 2014 Score | March 2015 Score |
|---|---|---|
| Operating Rooms | 86.85 | 80.36 |
| Inpatient Units | 80.89 | 75.32 |
| Outpatient Clinics | 89.23 | 82.70 |

The decrease in scores in high risk areas has produced an action plan to correct and sustain better results in these key areas.

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

Specific and measureable tactics have been implemented which will significantly improve the cleaning process and quality measurement capability in order to increase scores in Q1.
They include; Addressing the audit results, work observation and interim in-house audits, supervisor inspection schedules, additional Westech Certification Training (May 2015), workload balancing review and communication of the audit results and action plan to the KGH Leadership group.
In addition, an interim audit by Westech will be conducted during the summer of 2015 to measure progress on actions.

**Definition:** DATA: Bob Campeau COMMENTS: Bob Campeau STRATEGY REPORT

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

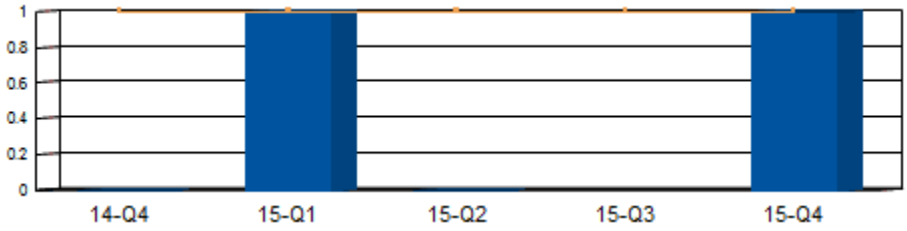
**Target:** Target 2012/13: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%,Target 2014/15: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

# Q4 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-Q4** | 0 | **1** |
| **15-Q1** | 1 | **1** |
| **15-Q2** | 0 | **1** |
| **15-Q3** | | **1** |
| **15-Q4** | 1 | **1** |

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

Activities to support progress on this tactic this last quarter have been focused on supporting the Ministry of Health and Long Term Care (Ministry) evaluate our submission and inform decision makers in the government about our project. All new information requests in Q4 from the Ministry have been completed. Several meetings were held with Ministry representatives during the quarter to inform senior Ministry and Government Officials about our project. In February the CEO drafted a letter for MPP Sophie Kiwala to send to the Minister of Finance with cc to Infrastructure Ontario and the Minister of Health requesting financial support to proceed to Stage 2 Functional Programming. Hospital staff also met with City officials to keep them apprised of progress and planning for the project. Some tours of the targeted areas in the hospital requiring redevelopment were also arranged to inform the City, Ministry, and Government.

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

At the end of Q4, we still have not received word as to whether the project will advance to stage 2. This is consistent with all other projects that are awaiting direction from the Ministry of Health and Long Term Care. Ministry approvals and announcements were all put on hold pending the Provincial Budget and decisions on project priority. While we continue to be concerned about the space and facility condition, programs and services continue to operate and manage in the existing facility, but in space that is undersized and outdated.

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

As noted above we did not meet our desired goal of obtaining approval by March 31, 2015. We are continuing to monitor the Provincial processes and continue to advocate for our project with key decision makers in the government. We have commenced planning our approach to Stage 2 and are developing time lines and work plans so that we can be quick to initiate action, if approved to proceed in Q1 of F2016. If KGH's Phase 2 is not approved in this round of announcements we will of course be back to advocate for our project with the Ministry and Government.

**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)

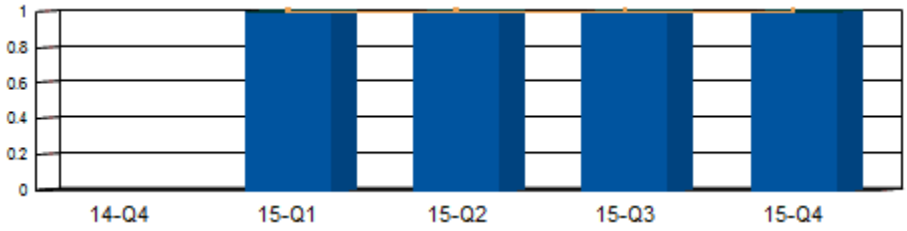
Kingston General Hospital

# Q4 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-Q4** | | |
| **15-Q1** | 1 | **1** |
| **15-Q2** | 1 | **1** |
| **15-Q3** | 1 | **1** |
| **15-Q4** | 1 | **1** |

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

The Hospital Information System (HIS) clinical and technical requirements were finalized and the RFP was assembled and ready for release prior to the Healthcare Tomorrow Project. To address the request from the CEOs for additional information related to funding, the Healthcare Tomorrow information service business function group reviewed all costs related to the HIS as well as identifying potential savings opportunities. These costs were included in the Healthcare Tomorrow IS business case. The CEOs also asked for additional information related to the governance required to operate a regional HIS. The broader service governance review under the Healthcare Tomorrow Project is intended to address this.

**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 are two major issues related to advancing the regional HIS. The first relates to the capital investment and the new operating expenses related to the investment. Second, the Ministry has now undertaken a larger provincial eHealth Governance 2.0 review. Key to this review is an HIS Renewal Advisory Panel which will review a range of issues, including best practices for consolidated procurements and methodologies to accurately estimate the cost of HIS renewal. At this point, HIS procurements that are based on urgent reasons are expected to demonstrate partnership models, evidence-based procurement, and long term financial 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?**

Yes. A decision to release the RFP is dependent on the completion of the Healthcare Tomorrow initiative. Pending the outcome, KGH will need to evaluate options to advance clinical systems independently. Such an approach would require KGH to complete its own long term financial planning.

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

**Target:** Target 14/15: As per implementation schedule

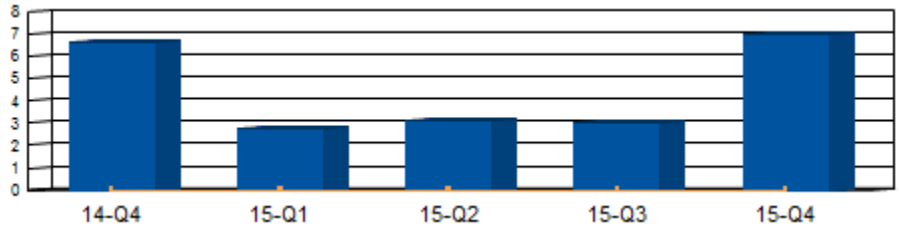
Kingston General Hospital

# Q4 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-Q4** | 6.67 | **0** |
| **15-Q1** | 2.77 | **0** |
| **15-Q2** | 3.08 | **0** |
| **15-Q3** | 2.99 | **0** |
| **15-Q4** | 7.03 | **0** |

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

Monthly financial reporting and analysis support continued to be provided to those with budget responsibility. Senior leadership continued to focus on working within budgeted parameters.

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

Essentially all identified operational efficiencies incorporated in the approved budget were actioned. Unplanned funding increases and miscellaneous revenue sources and the recognition of prior years' revenue upon program settlement offset negative operating variances aligned to increased patient care activity.

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

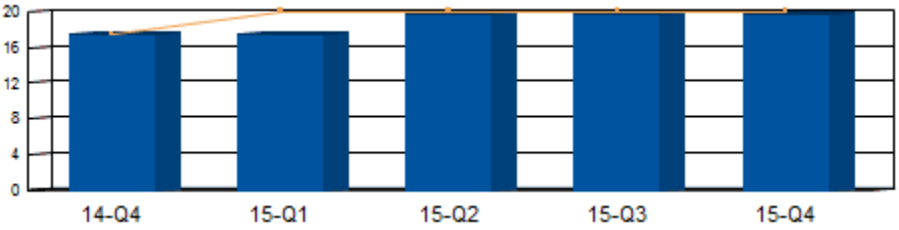
The hospital has developed a balanced operating budget for fiscal 2016 assuming a return to normal occupancy levels. Monitoring of patient care activity and implementation of planned operational efficiencies will be a key area of focus.

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

Operating margin "measures total operating revenues in excess of total expenses". It is a measurement of management's efficiency and the hospital's ability to live within available financial resources. Calculated as: Operating Surplus/(Deficit) divided by Operating Revenue. To ensure consistency in calculation between hospitals, the Province has provided a specific definition based on the Hospitals MIS Chart of Accounts. It is inclusive of all fund types (fund 1, 2, and 3), but excludes facility amortization).

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

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




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

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

The hospital achieved the targeted operational efficiencies for the year that contributed to increasing capital investment capacity.

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

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

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

The hospital has realigned estimated savings from operational efficiencies incorporated in the fiscal 2016 budget and therefore will be beginning the new year with a target of $19.0 million for capital investment.

**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

# Q4 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 |