fiscal 2015-2016 **Q1**

1st quarter ended June 30, 2015

KGH this quarter

Strategy Performance Report

Kingston General Hospital

Outstanding care, always

KGH Strategy Performance Report Fiscal 2016

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

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. KGH is recognized as a centre of excellence in interprofessional education

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

Enable High Performance

Outcome 7:

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

Strategic Performance Indicators

Outcome 8:

All preventable harm to staff is eliminated

KGH Strategy Performance Report Fiscal 2015 Q1

Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

Strategic Direction	2016 Outcome	Indicator	15-Q1	15-Q2	15-Q3	15-Q4	16-Q1	
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety, and service improvement initiatives	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	G	G	G	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	G	R	R	R	R	↑
		Hand Hygiene Compliance - (QIP)	R	R	R	R	R	↓
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	G	R	R	N/A	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	R	R	↑
		The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)	R	Y	R	R	R	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	G	G	G	G	G	↑
		Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)	N/A	N/A	N/A	N/A	Y	
		Number of Incidents Associated with Morphine or Hydromorphone	R	G	Y	G	G	↑
		Number of Specimen Collection and Labelling Errors	R	R	R	R	R	↑
	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	G	↑
		Percent ALC Days (QIP)	R	R	R	R	R	↑
		Overall Medical/surgical Occupancy Rate (Midnight Census)	Y	R	Y	Y	G	↑
		Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target	N/A	N/A	N/A	N/A	R	

Strategic Direction	2016 Outcome	Indicator	15-Q1	15-Q2	15-Q3	15-Q4	16-Q1	
	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	G	G	G	G	G	↑
Cultivate patient oriented research	Externally funded research at KGH has increased by 50%	William J. Henderson Centre for Patient-Oriented Research Implementation Plan is Meeting all Quarterly Milestones	N/A	N/A	N/A	N/A	G	
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	30 Day Readmission Rate Outperforms its Expected MOH rate (QIP)	Y	Y	Y	N/A	N/A	↓
		KGH Strategy Development Process Deliverables are met	N/A	N/A	N/A	N/A	G	
Enable High Performance	Staff are engaged in all aspects of our quality, safety, and service improvement initiatives	Does the organization provide opportunities for employee education, learning and development?	N/A	N/A	N/A	N/A	G	
		Number of Staff with Performance Reviews and Agreements on File	Y	R	G	G	R	↓
	All preventable harm to staff is eliminated	MSI injury recorded incidents that occur in staff as a result of inpatient mobilization are reduced by 20%	N/A	N/A	N/A	N/A	G	
		The incidents of workplace violence injuries are reduced from 50 to 44 per year	N/A	N/A	N/A	N/A	R	
	Phase 2 construction is under way and KGH is clean, green, and carpet free	Stage 2 Approval Status	Y	Y	Y	Y	Y	↑
		Percent Compliance with Cleaning Audits	Y	N/A	N/A	Y	N/A	
	Rapid transmission of information improves care and operational efficiency	Number of Strategic Technology Projects Implemented on Schedule	N/A	N/A	N/A	N/A	G	
	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 ↓

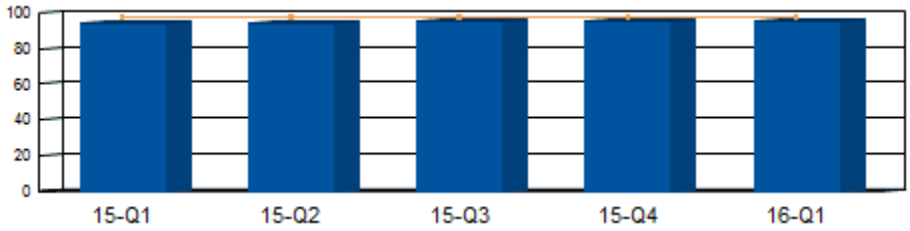
	Strategy					QIP					Supporting				
	FY15			FY16		FY15			FY16		FY15			FY16	
	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #	Q2 %	Q3 %	Q4 %	Q1 %	Q1 #
R	48%	44%	37%	37%	10	58%	67%	50%	50%	6	33%	34%	34%	39%	29
G Y	52%	56%	63%	63%	17	42%	33%	50%	50%	6	66%	66%	66%	61%	46
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	1%	0%	0%	0%	0
					27					12					75

Q1 FY2016 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
15-Q1	94	**97**
15-Q2	94	**97**
15-Q3	95	**97**
15-Q4	95	**97**
16-Q1	95	**97**

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

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

243 participants completed the training in Q1.Added to the 866 staff, learners and volunteers from the previous fiscal year, a total of 1109 people have completed the Communicate with HEART training.
The 243 trainees in Q1 represent 16% of the target of 1500 trainees for F15/16. We are further enhancing the training through a PDSA cycle combining an e-learning module with an in-class skills practice. The goal of this is to deliver the same learning with improved accessibility for learners.

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%. As the Communicate with HEART concepts are shared with more of staff, learners, volunteers and credentialed staff, we hope to have a significant impact on patient satisfaction. We believe we are on target to achieve this target by year end.

Definition: DATA: Astrid Strong COMMENTS: Astrid Strong EVP: Silvie Crawford REPORT: 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%, Target 15/16:97% Perf. Corridor: Red <=85% Yellow 85%-96% Green >=97%

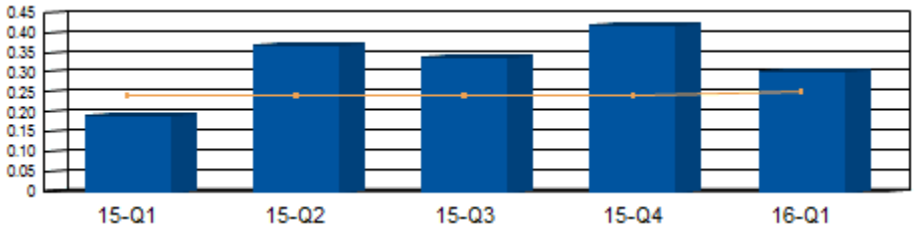
Kingston General Hospital

Q1 FY2016 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
15-Q1	0.19	**0.24**
15-Q2	0.37	**0.24**
15-Q3	0.34	**0.24**
15-Q4	0.42	**0.24**
16-Q1	0.30	**0.25**

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

The tactic work plan for 2015-2016 will see the continuation of strategies that have significantly contributed to the improving trend. These include diligent surveillance by IPAC of all confirmed and query CDI cases; daily ICP presence on the units and ED, working collaboratively with each Program/unit to ensure prompt initiation of "Contact Precautions" for any patient with diarrhea, notification of IPAC and timely specimen collection. Ongoing communication with the Microbiology Laboratory enhancing the reporting to IPAC of results including a lab generated 24 hour CDI report, pushed and printed in IPAC. Continued efforts between IPAC and Environmental Services to ensure appropriate use of sporicidal cleaners and prompt initiation of enhanced cleaning when clusters are identified.

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

In Q1 we identified 11 nosocomial cases; an incidence rate of 0.3 cases per 1000 patient days. Comparator hospitals had an average of 0.4 for this same time period. There was 1 case in April; in May there were 4 cases and in June there were 6 cases. The 6 cases in June included a cluster of 4 on one unit, the other 2 cases occurred on 2 separate units. Enhanced cleaning was done on the unit to address evidence of ongoing transmission and identified gaps in cleaning. In addition, education was provided for the nursing staff on the importance of cleaning shared equipment and the Program Manager designated PCA's would clean all shared equipment each evening. The importance of hand hygiene in the prevention of nosocomial transmission was also emphasized by the ICP and PM. No further transmission has been identified on this unit.

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 of 0.25 was not met, we continue a steady downward trend in the number of CDI nosocomial cases. The trend has been sustained for > 3 years; as of the end of June we marked 37 months without a CDI outbreak. In 2014 - 2015, we had 50 cases of CDI; in 2013 - 2014 we had 77 cases and in 2012 - 2013 we had 88 cases.
New tactics to improve the current trend for 2015 - 2016 includes the introduction of a change in processing CDI specimens in Microbiology Laboratory; increasing awareness of the CDI Order Set; and collaborating with ENSE on ensuring standardized isolation cleaning and discharge/terminal cleaning procedures for CDI patient's environment, equipment and bathroom are in place.

Definition: DATA: Darlene Campbell COMMENTS: Dr.Gerald Evans EVP: David Zelt REPORT: 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, Target 2015/16: 0.25 Red:>10% of Provincial Rate Yellow: Within 10% of Provincial Rate Green <= Provincial Rate

Q1 FY2016 Strategy Performance Indicators Report

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

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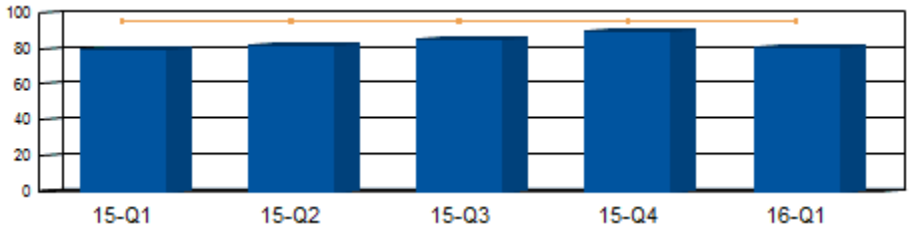
Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
15-Q1	80	**95**
15-Q2	82	**95**
15-Q3	85	**95**
15-Q4	89	**95**
16-Q1	81	**95**

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

The tactic work plan for 2015-2016 will see further roll out to auditors, the new resource tool (laminated poster) developed to clarify what is considered Patient Environment vs. what is considered Hospital Environment to provide "Just in Time" education. Additional units and their auditors have been identified for the next phase of the roll once changes are finalized based on feedback from those involved in the initial phase. Ensuring ongoing support is available to auditors as they continue to develop their comfort level and expertise using the device and observation skills.
The Hand Hygiene LMS module updates are being finalized. Additional information incorporated speaks to the importance of Moment 1 hand hygiene to patient safety; and appropriate use of gloves i.e. task specific and must include hand hygiene prior to putting them on and taking them off. Once uploaded, the module will be assigned as a mandatory session for all KGH employees.

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

In Q1 the corporate average for before patient/patient environment contact (M1) was 81%; the after moment (M4) was 90%. This is a decrease in our compliance rate from Q4 2014 - 2015 when our rate for M1 was 89.4%. These rates are the reflection of 3,140 HCW being observed which created 4,173 observed opportunities with compliance met in 3,550 of these opportunities. The increase in the number of 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?

Although our target of 90% was not met, the Hand Hygiene Working Group is continuing to meet to identify new strategies to refine efforts within the Programs and supports from IPAC Service to reach all staff. The further roll out of the new Resource Tool and the "Just in Time" intervention training and education 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 tactics to improve the current trend for 2015 - 2016 includes making the revised LMS module mandatory for all staff annually; changes to PGY 1 Workshop will focus on hand hygiene with interactive sessions that included appropriate hand hygiene, donning and doffing of PPE including gloves; revised the Infection Prevention and Control Manual Glove policy was sent to both the Joint Health & Safety Committee and the KGH/HDH Infection Control Committee in May for endorsement; policy to go to MAC for approval in September.

Definition:

DATA: Infection Control COMMENTS: Dr.Gerald Evans EVP: David Zelt REPORT: 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%, Target 15/16: 95% Red <84% Yellow 84% - 89% Green >= 90%

Q1 FY2016 Strategy Performance Indicators Report

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

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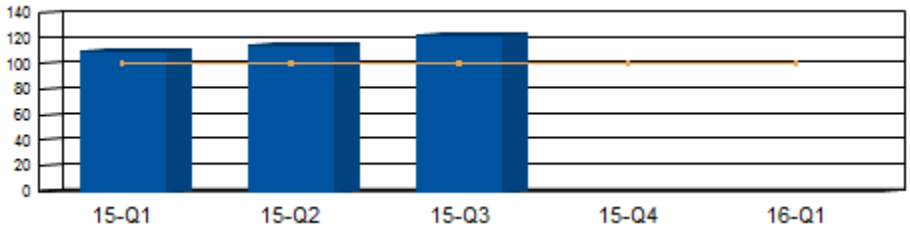
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
15-Q1	109	**100**
15-Q2	115	**100**
15-Q3	122	**100**
15-Q4		**100**
16-Q1		**100**

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

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

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

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 strengthening the comparisons that can be made between hospitals. 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 included in the data calculations. Inclusion of palliative deaths because of coding protocols at CIHI continues to be a difficulty in analysis.

In Q3 there were 167 deaths based upon 1862 cases used in the HSMR calculation. The 75th percentile HSMR for Peer Group is 101.

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 EVP: Dr. David Zelt REPORT: 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, Target 15/16: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

Q1 FY2016 Strategy Performance Indicators Report

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

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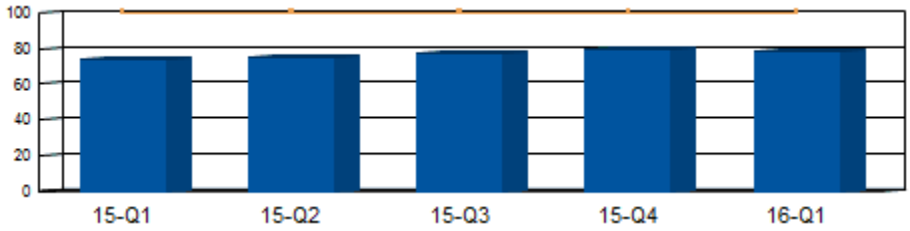
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
15-Q1	74	**100**
15-Q2	75	**100**
15-Q3	77	**100**
15-Q4	79	**100**
16-Q1	78	**100**

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

Three new tactics aligning with Hospital target: "Every patient receives medication reconciliation at admission" are included in the Fiscal 2015-16 Integrated Annual Corporate Plan Tactic worksheet:
1. Ensure Physician engagement in the medication reconciliation process
2. Implement a prescriber education program for medication reconciliation
3. The medication reconciliation process is embedded in all admission order sets

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 decreased from 79% in F15 Q4 to 78% in F16 Q1.

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

Physician education program and medication reconciliation policy in progress.
Admission order sets continue to be developed/updated to include the medication reconciliation process

Definition: DATA: Decision Support COMMENTS: Veronique Briggs EVP: Dr. David Zelt REPORT: 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%, Target 15/16: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

Q1 FY2016 Strategy Performance Indicators Report

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

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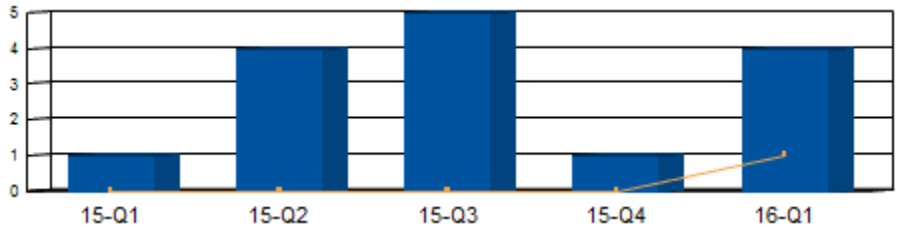
Indicator: The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)



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

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

The current work involves assessment of the two main areas of focus for this fiscal year; patient risk assessment (for falls) and mobility plans being in place for all patients. This work shows approximately 80-90% levels of achievement.

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

The Q1 results show four Level 3 falls were recorded, one in Critical Care, two in Mental Health and one in Medicine. As with all Level 3 and Level 4 incidents investigations are undertaken to review the circumstances related to the incidents and any lessons to be learned from those most closely involved in the event. Work will begin in Q3 focusing on increasing the percentage of risk assessments and mobility plans being completed for all patients.

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

Reducing to the average of 1 L3 or L4 fall per quarter is achievable; effort that teams are making to raise awareness of patients at risk and plans to mitigate is positive.

Definition: DATA: Decision Support COMMENTS: R. Jewitt EVP: Silvie Crawford REPORT: 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 reduce actual level 3 (moderate harm) and level 4 (severe/critical harm) patient falls from an average of 3 to 1 per quarter.

Target: Target 15/16: 1/qtr Red >3 Yellow 2-3 Green <=1

Q1 FY2016 Strategy Performance Indicators Report

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

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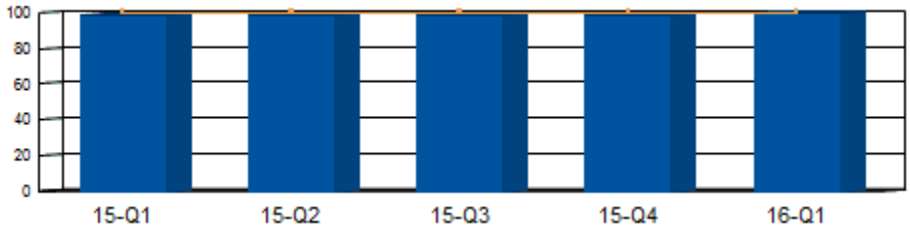
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



	Actual	Target
15-Q1	99	**100**
15-Q2	99	**100**
15-Q3	99	**100**
15-Q4	99	**100**
16-Q1	99.6	**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.

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

For Q1 this indicator continues to meet the green target corridor. There were 2,295 surgical cases completed in this quarter. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.9%, Timeout-99.7%, and Debrief- 99.9%. The unscheduled/emergent cases continue to influence this metric. There were 2 “A” cases and 3 “B” cases that did not complete the 3 phases of the checklist this quarter.

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

On track to meet this target.

Definition: DATA: Kathleen Wattie Barnett COMMENTS: Kellie Kitchen EVP: David Zelt REPORT: 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%, Target 15/16: 100% Red <85% Yellow 85%-94% Green: >95%

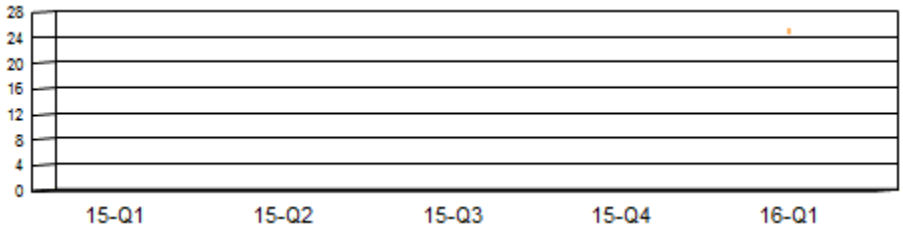
Kingston General Hospital

Q1 FY2016 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: Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)



	Actual	Target
15-Q1		
15-Q2		
15-Q3		
15-Q4		
16-Q1	25	

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

Supports have been put in place to allow documentation, safe reporting and auditing of risk assessment. Staff resource to start in July to enable pressure ulcer prevalence data and auditing data.
Changes will include documentation of actionable interventions based on the Braden risk assessment; addition of skin & wound integrity category in Safe Reporting System; and mandatory learning module for staff.

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

The three units (Kidd 6 general surgery, Connell 10 medicine and Kidd 2 ICU critical care) were chosen because these units had the highest wound prevalence in the February 2014 study (Kidd 6 27%; C10 35%; K2 ICU 47%).
Prevalence data and risk assessment/skin assessment data will be available starting July. First of the monthly pressure ulcer prevalence studies has been completed and is being analyzed at this time.

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

We are on track to meet targets by year end by having supports in place and ability to collect and monitor data.

Definition: DATA: Leanne Wakelin COMMENTS:Leanne Wakelin EVP: Silvie Crawford REPORT: STRATEGY REPORT

Twenty-five per cent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) with the highest prevalence. This will result in 4 less incidents in the ICU, 2 on C10, and 2 on K6.

Target: Target 2015/16: 25% reduction Perf. Corridor: Red 1 or 2 units achieve Green Status, Yellow 1 or 2 units achieve Green Status, Green 3 of 3 units achieve green status

Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

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

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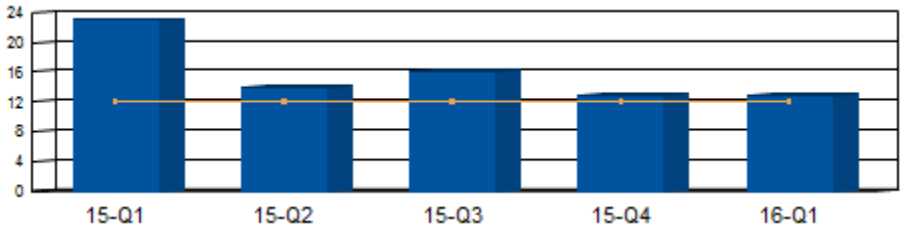
Indicator: Number of Incidents Associated with Morphine or Hydromorphone



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

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

Morphine & Hydromorphone nursing education continues. The hydromorphone alert built in the Automated Dispensing Cabinets (ADCs) remain.

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

In Fiscal 2015-16 Quarter 1 (April 1, 2015 to June 30, 2015), there were 13 reported morphine and hydromorphone medication administration incidents. This is just above the improvement priority target of 12 for this quarter.
None of the incidents were reported as level 3 (moderate harm) or level 4 (serious/critical incidents).
Out of the 13 reported administration incidents, three involved morphine and 10 involved hydromorphone. There were no incidents involving morphine administered when hydromorphone was ordered, nor any incidents involving hydromorphone being given when morphine was ordered.
Administration incidents were mostly reported with hydromorphone compared to morphine and included incorrect dose/strength, incorrect frequency, incorrect formulation, incorrect route, administration omission, and one "other" which involved a malfunctioning PCA pump.

With very similar names and given the fact that hydromorphone is approximately 5 times as potent as morphine on a mg per mg basis it is especially important to avoid hydromorphone administration when morphine was ordered.

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

Fifty five percent of nurses have completed the education module as of June 30, 2015.

Definition: DATA:Veronique Briggs COMMENTS: Veronique Briggs EVP: Dr. David Zelt REPORT: 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, Target 2015/16: 12 Perf. Corridor: Red >20 Yellow 16-20 Green <=15,
Target 2015/16: 12 Perf. Corridor: Red >20 Yellow 16-20 Green <=15, Target 2015/16: 12 Perf. Corridor: Red >20 Yellow 16-20 Green <=15

Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

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

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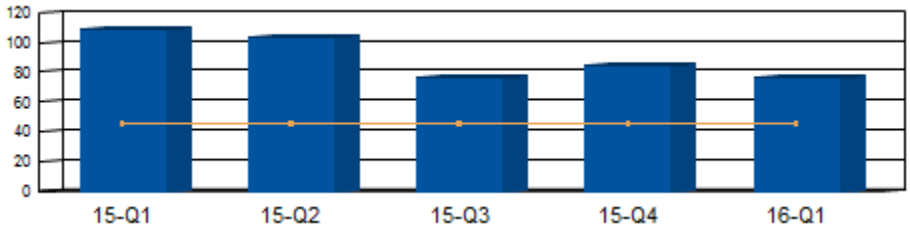
Indicator: Number of Specimen Collection and Labelling Errors



	Actual	Target
15-Q1	109	**45**
15-Q2	104	**45**
15-Q3	76	**45**
15-Q4	84	**45**
16-Q1	76	**45**

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

Laboratory tests are used to screen, monitor or diagnose disease states. It is imperative that the "six rights" of specimen collection are followed. This means identifying the right patient and following the correct specimen collection procedures. All specimen collection errors present a risk to the organization. By engaging stakeholders with consistent communication and education we expect to increase conformance to specimen collection policy procedures and practices. As the units move towards the implementation of communication boards that include data on specimen collection incidents this will help awareness around specimen collection.

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

While the number of specimen collection incidents fell from 109 in Q4 of F15 to 76 in Q1 of F16 the target is still red. The decrease is due to several factors. The EDIS project went live in June of Q1 and a pilot project involving the phlebotomy team was in place involving the D4 ICU location. Both initiatives have shown already an increased compliance to specimen collection resulting in fewer specimen collection incidents. The ICU pilot involved an inter professional team to identify opportunities and successfully implemented the recommendations. The clinical laboratory staff continues to provide just in time education to nursing units staff to help perform the task of specimen collection according the "six rights" of specimen collection.

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

Close monitoring of specimen collection incidents needs to continue. Data from the first month of Q2 shows a total of 23 specimen collection incidents. Year over year (June F'15 had 41 specimen collection incidents vs. June F16 with a total of 18 specimen collection incident). Trending is in the right direction. EDIS go live and the D4 support of the phlebotomy team is now in place. All personnel responsible for specimen collection must follow the established policies and procedures. The clinical laboratory staff are ready, willing and able to engage with care teams and learners to provide information so that specimen collection at point of care follow the established policy and procedures that are already in place. This is imperative in order for the corporate target to be met.

Definition: DATA: Joyce deVette-McPhail COMMENTS: Joyce deVette-McPhail EVP: Dr. David Zelt REPORT:STRATEGY REPORT

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

Target: Target 2014/15: 45 Perf. Corridors: Red >75. Yellow 56-75 Green <=55,Target 2015/16: 45/qtr. Perf. Corridors: Red >55/qtr. Yellow 46-55/qtr. Green <=45/qtr.

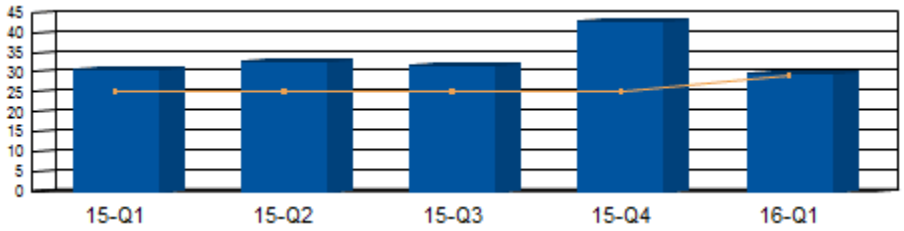
Kingston General Hospital

Q1 FY2016 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
15-Q1	30.7	**25**
15-Q2	32.6	**25**
15-Q3	31.6	**25**
15-Q4	42.7	**25**
16-Q1	29.7	**29**

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. Having met this goal, the focus now is to sustain gains made and identify further opportunities to reduce bed empty time which will result in a reduced ED LOS for patients who are admitted. The Patient Flow Task Force, which has representation from across all programs and services as well as CCAC and Providence Care, continues to meet twice a month and has oversight of patient flow within KGH as well as transfers to other organizations and discharges home with support.

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

The Q1 result of 29.7 hours is slightly above the 29 hour target. The target for this indicator was changed from 25 hours last year to 29 hours this year. Based on Q1 admission volumes of 2821, 254 patients waited more than 29.7 hours in the ED for an inpatient bed. Admission rate from the ED is just over 20% which is higher than the average Ontario teaching hospital rate of 15.8%. Patients with extended LOS in the ED are in the wrong place to receive optimum care. As well, longer boarding times mean that patients waiting for inpatient beds are occupying a significant percentage of the bed capacity in the ED limiting the number of new patients who can be seen. LOS in the ED is continuously monitored in real time with EDIS, and supports timely and factual communication with inpatient units to support planning. Performance of our peers: LHSC = 25.4, HHSC = 24, SMH = 22.5, SHSC = 24.2, TOH = 24, TBRHC = 29.4, teaching hospital group 25.5. We are meeting our target but we not performing as well as our peers which puts us at risk for Pay for Results Funding. Our funding rank for admitted patients is 56 for current performance and 63 for improvement out of 74 hospitals as of the end of June.

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

Yes. We need to continue to sustain gains made through GOOG initiatives and continue to fine tune processes resulting in reduced bed empty time.

Definition: DATA: Decision Support (NACRS) COMMENTS: Julie Caffin EVP: Silvie Crawford REPORT: 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.

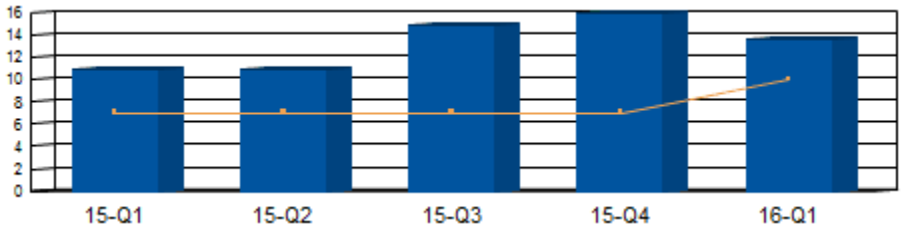
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 15/16: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

Q1 FY2016 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
15-Q1	11.0	**7**
15-Q2	11.0	**7**
15-Q3	14.8	**7**
15-Q4	16.0	**7**
16-Q1	13.7	**10**

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

KGH and regional partners have committed to focus on ALC and as a result, a number of initiatives are underway. Within KGH, steps that are being taken include:

- A registered nurse has been seconded to be the KGH point of contact for ALC patients and patient flow issues.
- A 'tiger team' meets bi- 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 its 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. Two Patient Experience Advisors have joined the ALC Tiger Team to assist with planning and implementation of various initiatives.
- 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.
- Current order set for ALC designation was revised in June 2015 to introduce a new interprofessional process for assessment and decision making regarding ALC for long term care.
- A value stream map in underway to map the current & future processes that support flow of patients designated ALC to the most appropriate destination.
- Working closely through a regional Patient Flow peer group that is made up of representatives from all hospitals, the CCAC & 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. In Q1, the Patient Flow Peer Group started site visits to each hospital in the SE to bring forward recommendations to drive change and improvement based on best practices in place across the region. Remaining visits to take place in Q2.

CCAC staff are involved in any discharge challenges related to specific patients & work closely with KGH staff members. Monthly meetings with KGH & CCAC leaders will begin in Q2.

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

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 Q1 result of 13.7% indicates that, on average, there were more than 50 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.

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 10% this quarter. Despite significant efforts across hospitals and the SE CCAC, ALC rates have been escalating over the past year. The continued rise in the numbers of patients designated as ALC is of great concern. The team is discussing options to optimize care of patients with chronic or complex conditions through Health Links and reduce avoidable hospital admission from long term care homes or retirement homes. KGH staff members are participating in a LHIN-based peer to peer patient flow task team to develop policies and processes that will be implemented across all SE LHIN organizations.

Definition: DATA: Decision Support COMMENTS: Cynthia Phillips EVP: Silvie Crawford REPORT: 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.

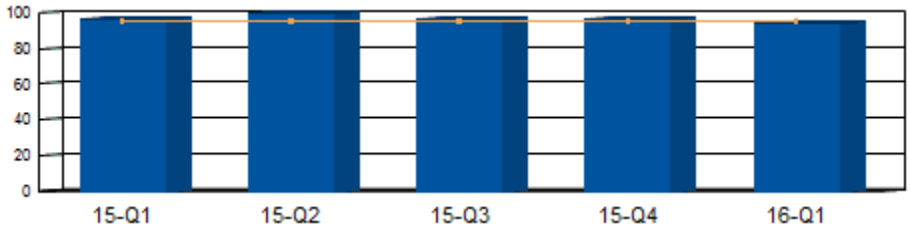
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q1 FY2016 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
15-Q1	96	**95**
15-Q2	100	**95**
15-Q3	96	**95**
15-Q4	96	**95**
16-Q1	94	**95**

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

Considerable focus on the “Get out of Gridlock” (GOOG) initiatives as well as the ongoing work with the ALC task continues to identify opportunities for improvement with patient access to care. KGH continues 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 Q1 overall medical/surgical occupancy rate has been achieved and exceeded by 1 % this quarter. The factors that have influenced the rate are the number of initiatives underway to address overall patient flow.
There continues to be variation between the occupancy rates of the clinical programs and as such, there is continued work to better understand various program influences.

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

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. Early results from Q2 show a number of Programs with reduced occupancy.

Definition: DATA: Decision Support COMMENTS: Silvie Crawford EVP: Silvie Crawford REPORT: 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%,Target 15/16: 95% Perf. Corridors: Red >=100% Yellow 96%-99% Green =95%

Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

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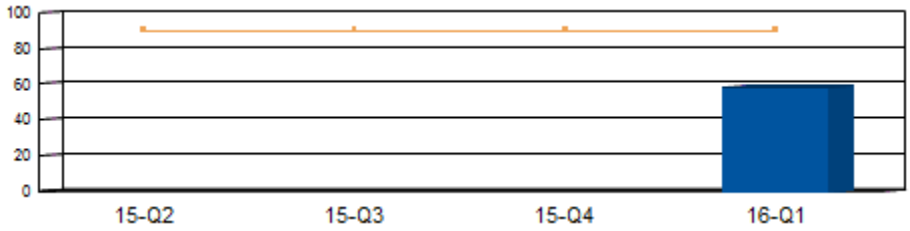
All preventable delays in the patient journey to, within, and from KGH are eliminated

Indicator: Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target



	Actual	Target
15-Q2		**90**
15-Q3		**90**
15-Q4		**90**
16-Q1	58	**90**

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

Under the leadership of the Executive Vice President Medical, a review of the wait time committee structure and quality based procedure (QBP) committee structure has taken place. The result of these findings as lead to a tactic that will see these to committees merge under a revised terms of reference and modified membership. The new committee will be focused on the both monitoring wait times as well as volume targets associated with QBPs and other incremental volumes and the critical interface between the two.

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 reflects the MoH's a new methodology for monitoring wait time performance. It focuses on the percentage of cases completed in the least urgent priority category. Patients on waiting lists are given a priority score (as per MoH methodology) from 1 (the most urgent) to 4 (the least urgent). This indicator is monitoring the performance of cases assigned to the priority 4 categories. 12 of 28 (58%) surgical categories did not meet the 80% completed within target threshold. 1 Gen Surg, 2 Gyn Surg, 3 Neuro Surg, 2 Ortho Surg, 4 Urol surg. To reach green status, 25 of the 28 categories must have completion rates of 80% or higher. It is important to note that for the most part the case counts in each of these 12 categories not meeting target were low and half of were close to meeting the 80% completion threshold.

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 work planned for more focused review and monitoring at the committee level, it is anticipated that this indicator will at least reach yellow status.

Definition: DATA: Decision Support COMMENTS: John Lott EVP: Dr. David Zelt REPORT: 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.

Target: Target 2014/15: 182 days Perf. Corridors: Red <80% Yellow 80% - 90% Green 90%+,Target 2015/16: 90% days Perf. Corridors: Red <80% Yellow 80% - 90% Green 90%+

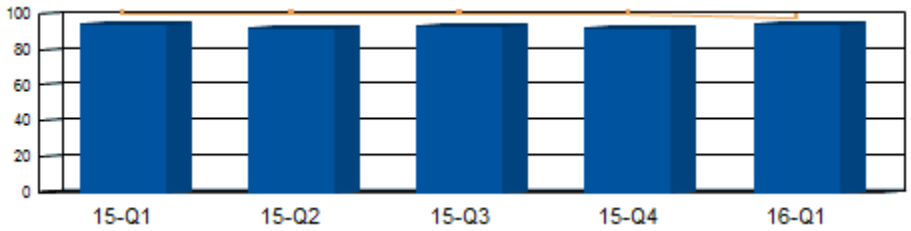
Kingston General Hospital

Q1 FY2016 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
15-Q1	94	**100**
15-Q2	92	**100**
15-Q3	93	**100**
15-Q4	92	**100**
16-Q1	94	**98**

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 98% 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. 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 7819 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those audits 94% were in compliance. The individual standards are being reported at a corporate compliance rate of at least 93%. (Badges 93%, whiteboards 93%, Communication 97%, hourly rounding 97%) For those areas not meeting the goal directors and managers look to find ways of supporting staff and physicians to increase their compliance.
The # of feedback forums completed stands at 3.

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

We are on track to meet this target.

Definition: DATA: Daryl Bell COMMENTS: Daryl Bell EVP: Silvie Crawford REPORT: 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.

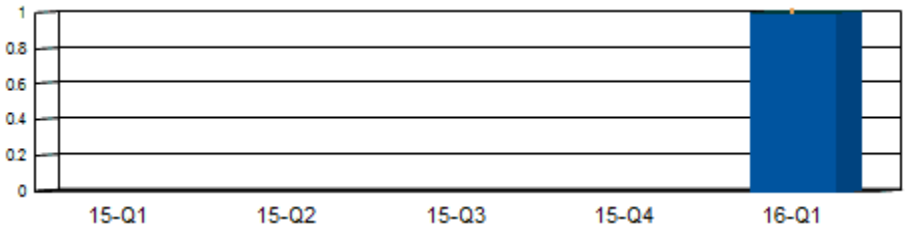
Target: Target 14/15: 100% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%,Target 15/16: 98% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%

Q1 FY2016 Strategy Performance Indicators Report

Cultivate patient oriented research

Externally funded research at KGH has increased by 50%

Indicator: William J. Henderson Centre for Patient-Oriented Research Implementation Plan is Meeting all Quarterly Milestones



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

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

The Ministry of Health and Long-Term Care (MOHLTC) approved our pre-capital submission of the Connell 4 project on March 19, 2015, allowing us to submit up to Stage 3.2 (Sketch Plan Approval) for both Phase 1 and 2 of the project. Based on the amount of secured funds received at the time of the pre-capital submission to the MOHLTC, only Phase 1 of the construction project was to be rolled out. Stage 3.2 was submitted this quarter and we have recently received follow-up questions from the MOHLTC that are being addressed. Once the MOHLTC has approved Stage 3.2, we can then prepare and submit Stage 4.1 (Pre-Tender Submission) documents to the MOHLTC. Staff located on Connell 4 now are being relocated over the next 2-3 quarters to ensure the area is vacant before construction commences. UHKF has reached their fundraising goal ($3.0M) this quarter for the W.J. Henderson Centre for Patient Oriented Research by re-directing $630,300 of existing foundation funds towards the Connell 4 project. This additional financial support, along with pledges received to date since the original pre-capital submission went into the MOHLTC in the fall of 2014, is now allowing us to increase our construction project budget from $3.2M to $4.2M. The total cost for Phase 1 and 2 of the project is ~$6.0M. This significant increase in secured funds will allow us to renovate more of the space on Connell 4 originally planned for Phase 2.

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 W.J. Henderson Centre for Patient Oriented Research is a significant milestone in demonstrating the KGHRI's mission of "discovery today, treatment tomorrow" – not just in high-profile, well-known diseases, but also in the hidden, less well-known conditions that affect Canadians. Dr. Jennifer Flemming's novel research into liver disease, described in the Gazette profile extracted below, is an example of how this commitment to research can have a profound impact on a once-incurable condition.

Chronic liver diseases are steadily growing conditions, estimated to affect one in 10 Canadians. Most chronic liver diseases are "silent", attacking the liver for decades without symptoms until revealing themselves through end-stage liver diseases such as cirrhosis, liver failure or liver cancer. Dr. Jennifer Flemming is the first in Canada studying the links between cirrhosis and biliary tract cancer (a rare subset of liver cancer) from both a clinical and population perspective. Key to her work is leveraging information in large patient databases. Her ground-breaking work will enable her to quantify the burden of biliary tract cancer across the Ontario population, and then identify disease trends, risk factors, and outcomes. This will be done by merging her databases with provincial health records. "Once we do this, we can figure out where more research is needed, who the target populations are for screening, and how and when to treat them," Dr. Flemming says. Long-term, she hopes to use the results of her population-based research to justify the development of a chronic disease management strategy for Canadians with liver disease. "It's important for people to know that the face of the disease is changing, that it's curable," she says. This news story was extracted from an article in the Queen's Gazette (May 2015) written by KGHRI's Communications Specialist, Mary-Anne Beaudette.

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

Renovations to Connell 4 to build the W.J. Henderson Centre for Patient Oriented Research will be now delayed due to staffing reductions at the MOHLTC which has extended their review period from 6 weeks to 12 weeks at each stage of the construction project. We are now looking at hopefully going to tender in the fourth quarter of F2016, with construction commencing in the second quarter of F2017. We anticipate the Centre opening up in the third quarter of F2017. There is nothing that can be done to expedite the process. As a result we have revised our original targets accordingly for each quarter this fiscal. Based on the revised targets, we are on track to meet our target at year end.

Definition: DATA: V. Harris-McAllister COMMENTS: V. Harris-McAllister EVP: Roger Deeley REPORT: SUPPORTING INDICATOR

Research space at the hospital currently totals 5,429 m2 (58,417 sq. ft). This research space supports over 500 researchers, research staff, students, and trainees. Over the last several years, providing suitable research space to support the research community has been a challenge. To meet the needs in our existing areas of strength, additional research space is vital to sustaining our capacity to support our research community today and tomorrow. Connell 4 has been identified as the location of the new W.J. Henderson Centre for Patient-Oriented Research. The Centre is slated to open tentatively August 2016. The creation of the new Centre will help to improve researchers' and patients' access to high quality services, create a readiness for future research system transformation and make the best use of the stakeholders and public investments. The multidisciplinary research programs that will be a part of the new Centre are well positioned to translate research into practice, increase public and private sector partnerships, develop new intellectual property, and translate knowledge that can directly influence the standard of care delivered in the region and beyond to our community.

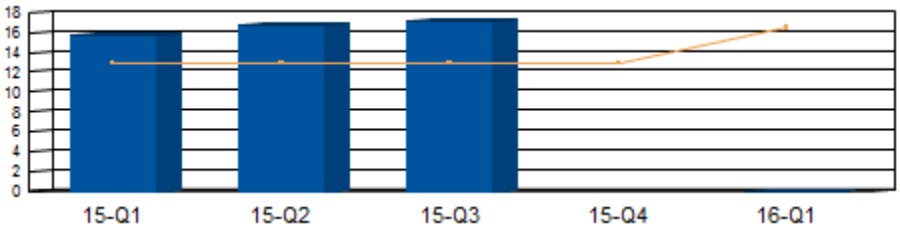
Target: Target 15/16: As per stated project milestones Perf. Corridor: Red 0 = No Yellow N/A Green 1=Yes

Q1 FY2016 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: 30 Day Readmission Rate Outperforms its Expected MOH rate (QIP)



	Actual	Target
15-Q1	15.80	**12.90**
15-Q2	16.74	**12.90**
15-Q3	17.18	**12.90**
15-Q4		**12.90**
16-Q1		**16.47**

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

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

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

Current performance is well above target, however it is worth noting that this performance dates back to Q3 of last fiscal year. This readmission rate calculation takes into account readmissions to any hospital, not just the KGH and therefore we cannot replicate this calculation and must wait until it is provided by MoH. Unfortunately it is not clear what our current performance is.

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

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

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

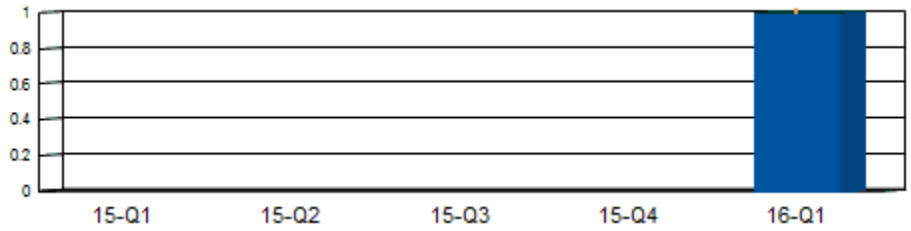
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected Green At or below expected

Q1 FY2016 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: KGH Strategy Development Process Deliverables are met



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

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

The KGH Strategy Development Process Document describes the process for creating the next long-term strategy for KGH. It has been approved by the governance committee of the KGH board, as well as our Strategy Advisory Council. As part of that plan we completed our current state analysis in Q1. The tactics that were implemented include:

- Wrapping up Team Talks and Council conversations, in which over 700 KGH staff, physicians, volunteers, learners and Patient Experience Advisors were engaged in a conversation about what we've achieved and learned over the past five years and what big opportunities and challenges must be factored into our long-term plans.
- Delivering our five-year strategy report. The report tells the story of our progress and encapsulates the salient points of our current state analysis as a basis for planning for our future. It received significant attention within the organization, in our community and throughout the health care industry as measured by feedback, web and social media statistics (details included in our Q1 media report).
- Participating and providing leadership to the Health Care Tomorrow Hospital Services process – a collaborative effort between hospital and system leaders within the SE LHIN to explore the future of hospital services in our region and to develop a sustainable hospital system that delivers integrated and high quality care for patients and families.

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

Having implemented the planned tactics within our Strategy Development Process we are on schedule with our work plan.

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. In the remaining quarters of this fiscal year, we will finalize our plans for phase two of our strategy development process, continue to participate in Health Care Tomorrow, design, test and validate our plans for the future with our stakeholders, document, launch and sustain communications about the next long-term strategy for KGH.

Definition: DATA: Theresa MacBeth COMMENTS: Theresa MacBeth EVP: Leslie Thompson REPORT: STRATEGY REPORT

Target: Target 2015/16: YES (1) Perf. Corridor: Red NO (0), Yellow (N/A), Green (1)

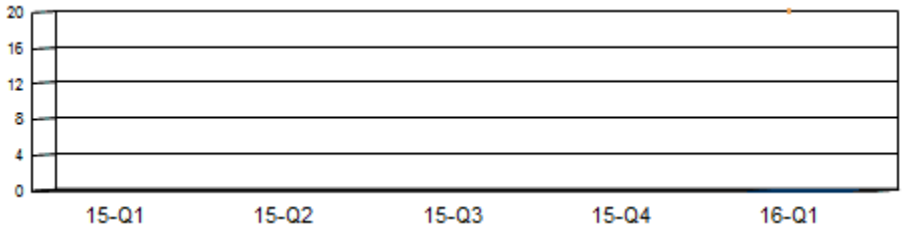
Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

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

Indicator: Does the organization provide opportunities for employee education, learning and development?



	Actual	Target
15-Q1		
15-Q2		
15-Q3		
15-Q4		
16-Q1	0	**20**

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

New positions started in interprofessional education and were solidified in Leadership & Learning to support the learning redesign strategy. The LEADS capabilities framework and competency assessment was released to leaders to assist in supporting staff in performance and development conversations. Pieces of the leadership development strategy began to be released. Funds for corporate education were finalized and areas such as workplace violence, patient and family centered care, interprofessional education and leadership training were areas of focus for support. Harvard ManageMentor was purchased and launched for leaders to support their development. A talent review was conducted for senior leaders and a draft engagement survey action plan was completed.

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 area of focus for corporate engagement relates to the question " Does the organization provide opportunities for employee education, learning and development?" and achieving a 20% increase on the next engagement survey. One of the areas of focus from the last engagement survey identified for the corporate plan included building around education, learning and career development.

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

On track. Engagement Survey planning will continue as a lead up to the fall staff, physician engagement survey. This will occur in Q3. A support framework for learning needs will be developed and implemented. Mental Health in the workplace training will take place for leaders. Further communication to all levels of the organization regarding learning supports will assist in awareness of the education and learning activities at KGH.

Definition: DATA: M. Mulima COMMENTS: M. Mulima EVP: Jim Flett REPORT: STRATEGY REPORT

Staff who respond "yes" to "does the organization provide opportunities for employee education, learning and development" improves by 20% (add together % of those who responded "yes").

Target: Target 2015/16: 20% increase Perf. Corridor: Red <10% increase, Yellow 10-20% increase, Green 20% increase

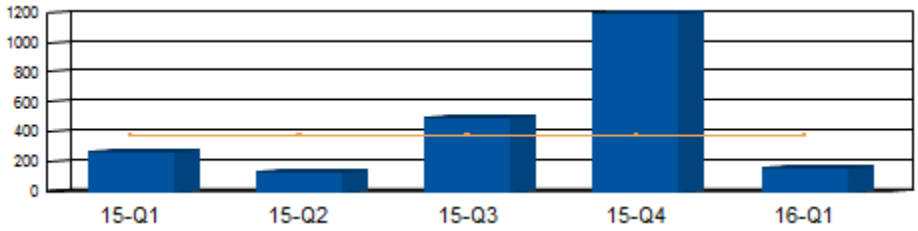
Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

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

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



	Actual	Target
15-Q1	259	**375**
15-Q2	132	**375**
15-Q3	495	**375**
15-Q4	1,198	**375**
16-Q1	158	**375**

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

158 performance plans were submitted in Q1. The deadline for non-union plans shifted into Q2 so it is anticipated these plans will increase next quarter. The RFP for an automated Talent Management performance & goals implementation partner moved forward and is in the selection process.

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 target was part of a two year commitment to ensure performance conversations were happening at the individual level whereby an additional 1500 performance plans are to be completed which will ensure it becomes part of our ongoing commitment to this endeavor. Staff are more engaged when they have had opportunity to discuss goals and performance with their leader and how they can contribute.

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

To date we now have 2113 overall since we began our focus in 2014-15. Q2 areas of focus will be on non-union performance agreements and reviewing linkages to compensation. Further information sessions will be held to ensure staff and leaders are well equipped to complete and have performance conversations. Prompts and reminders are sent to leaders regarding their progress on this metric.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima EVP: Jim Flett REPORT: 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.

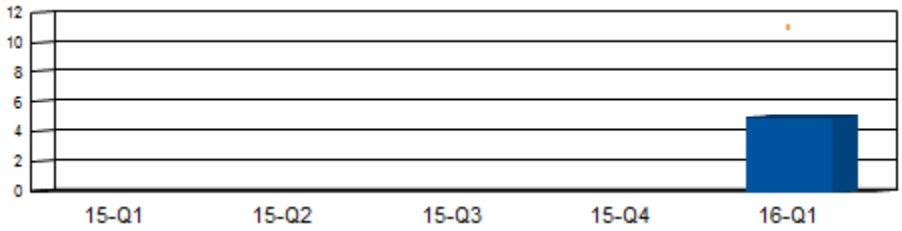
Target: Target 14/15; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375
Target 15/16; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

All preventable harm to staff is eliminated

Indicator: MSI injury recorded incidents that occur in staff as a result of inpatient mobilization are reduced by 20%



	Actual	Target
15-Q1		
15-Q2		
15-Q3		
15-Q4		
16-Q1	5	**11**

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

Staff in-services provided with focus on conducting patient mobility assessments and training on the safe use of floor model lift to lift a patient who has fallen.

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

In total there were 17 MSIs that occurred due to patient handling with the majority occurring on Connell 9 and Connell 10. Five (5) of the 17 injuries resulted in WSIB health care claims; there were no lost time injury claims due to patient handling this quarter.

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

On track

Definition: DATA: J. Noonan COMMENTS: J. Noonan EVP: Jim Flett REPORT: STRATEGY REPORT

Musculoskeletal (MSI) injury recorded incidents from staff are reduced from 53 to less than or equal to 42 per year (reduced 20%).

As the most prevalent type of injury in the healthcare sector, 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. Last year, MSIs that occurred during patient handling activities/patient mobilization represented over 30% of our lost time injury (LTI) claims and 50% of our health care claims submitted to the WSIB. We have seen an overall sharp increase in patient handling-related MSIs.

Through regular patient mobility assessments, use of appropriate patient handling techniques, and use of appropriate assistive equipment, we reduce the risk of injuries to patients and staff. Through the prompt investigation of MSI-related healthcare and lost time injury claims with support of the KGH Ergonomist, we are better positioned to identify root causes of MSIs and actions/improvements to reduce the likelihood of injury recurrence.

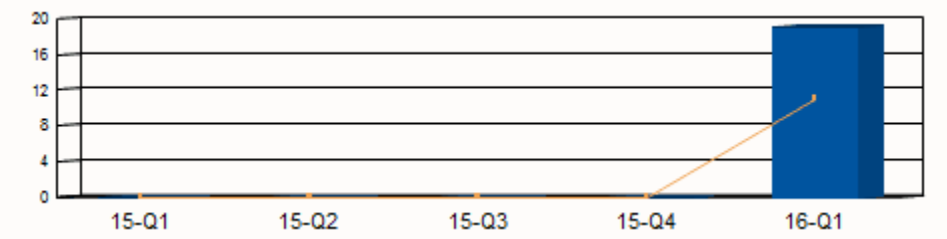
Target: Target 2015/16: 42 (11/qtr.) Red >47 (>13/qtr.), Yellow 43-47 (12-13/qtr.), Green <=42 (<=11/qtr.)

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

All preventable harm to staff is eliminated

Indicator: The incidents of workplace violence injuries are reduced from 50 to 44 per year



	Actual	Target
15-Q1	0	**0**
15-Q2	0	**0**
15-Q3	0	**0**
15-Q4	0	**0**
16-Q1	19	**11**

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

Daily patient violence risk assessment incorporated into the Patient Care Records in Pediatrics and Critical Care; only area outstanding is the ED and plans are underway to investigate incorporation of the risk criteria into EDIS. Audits done on 12 units to measure completion of risk assessments showed an average completion rate of 90%. Unit violence risk assessments initiated for clinical areas in Q1. Violence Prevention Taskforce has developed an action plan with a number of identified areas for improvements already implemented or planned.

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

In all, 41 safe reports were submitted in relation to violence; of these, 19 staff reported injuries. The majority of injuries required no treatment or first aid only; 3 resulted in health care treatment being sought and 1 resulted in lost time. The majority of injuries occurred in the Mental Health Program (n=8) and Medicine Program (n=7).

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

While audits show high completion for patient violence risk assessments, those measuring the application of the Behavioural Crisis Alert (BCA) Program, where a patient risk identified, show lower compliance at 70%. Focus in Q2 is on ensuring application of the BCA Program including the development of a risk reduction/care plan. Staff training to assist in this regard is being developed in Q2.

Definition: DATA: J. Noonan COMMENTS: J. Noonan EVP: Jim Flett REPORT: STRATEGY REPORT

This indicator in fact measures the number of employee injuries that result from incidents of violence that occur in the hospital. These injuries are the result of physical aggression/violent behaviour exhibited by patients and result in injury to the employee. Incidents that occur but do not result in injury are monitored, but are not included in this metric. Through a number of initiatives that are focused on identifying and communicating risk and care planning for risk reduction, our goal this year is to improve the management of at-risk patient behaviour so that incidents occur less often or are less severe resulting in reduced injury to employees.

Target: Target 2015/16: 44(11/qtr) Perf. Corridor: Red >49(>13/qtr.), Yellow 45-49 (12-13/qtr.), Green <=44 (<=11/qtr.)

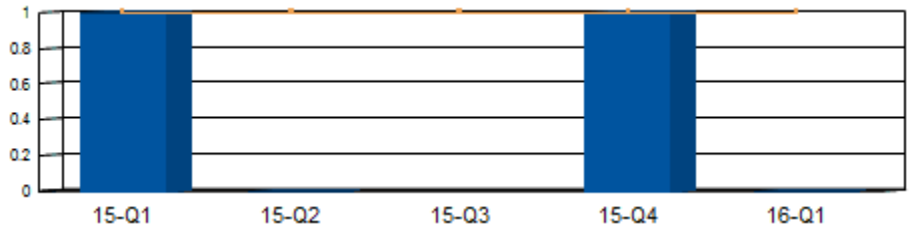
Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

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

Indicator: Stage 2 Approval Status



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

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

We continue to actively follow up with the Ministry of Health and Long Term Care Administration on the status of capital approvals and specifically our Phase 2 project. No new information was available in Q1. Work also continues on preparing our work plan and approach for Stage 2 Functional Planning once approved.

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

All the work requested by the Ministry to support their discussions and decision making were provided in F2015. No new requests have been received. Phase 2 remains a fundamental building block in ensuring the future capacity of the hospital to continue to meet the health care needs of the region. Once approved for Phase 2, it is anticipated that the project would take at least six years to complete.

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 continue to hear positive feedback but nothing to date confirming when we will hear officially on the status of our project.

Definition: DATA: Allan McLuskie COMMENTS: Allan McLuskie EVP: Jim Flett REPORT: 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.

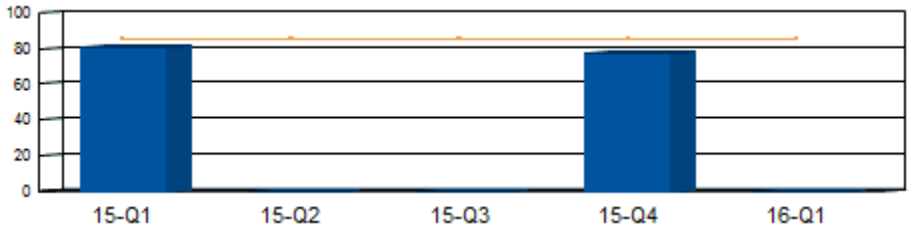
Target: Target 13/14 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes,Target 14/15 (1/0 = Yes/No) Perf. Corridor: Red 0 Yellow N/A Green 1(1 = Yes 0 = No),Target 15/16 (1/0 = Yes/No) Perf. Corridor: Red 0 Yellow N/A Green 1(1 = Yes 0 = No)

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

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

Indicator: Percent Compliance with Cleaning Audits



	Actual	Target
15-Q1	81	**85**
15-Q2		**85**
15-Q3		**85**
15-Q4	77	**85**
16-Q1		**85**

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

Results represent the avg of 2 in-house Westech audits conducted during the 1st quarter

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

These in-house audits represent marked improvement from the previous March 2015 audit and indicate performance is heading towards the target of 85.

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

Yes. On track to meet our target as we increase the number of in- house and work observation audits.
The interim Westech audit (external) conducted in July produced a score of 80.3% which further demonstrates our positive movement.

Definition: DATA: Bryan Harvey COMMENTS: Bryan Harvey EVP: Jim Flett REPORT: 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%,Target 2015/16: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

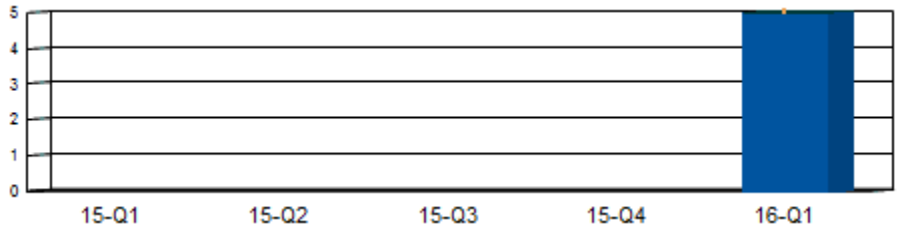
Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

Rapid transmission of information improves care and operational efficiency

Indicator: Number of Strategic Technology Projects Implemented on Schedule



	Actual	Target
15-Q1		
15-Q2		
15-Q3		
15-Q4		
16-Q1	5	**5**

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

The Staff Scheduling and Time Capture project began the first of several roll-outs scheduled for the next couple of months. The Automated Chemistry Track project was initiated and the planning phase was completed. There are no significant updates to report with the Web Redevelopment project as it continued to execute as planned. The cNEO provincial project was started in Q1 (agreements with TOH were signed, recruitment was completed and project deliverables were started). The HIS RFP is currently awaiting direction from the Health Care Tomorrow project before significant progress can be made.

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

At present there are no concerns with the project portfolio's performance (we are on track as planned). This project portfolio delivers on our commitment to outstanding care by ensuring patient information is shared regionally and provincially, patients are engaged via website communications and timely and accurate laboratory results are received.

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

These projects are on track for completion by the end of Fiscal 2016.

Definition: DATA: Troy Jones COMMENTS: Troy Jones EVP: Jim Flett REPORT: STRATEGY REPORT

Strategic technology projects are implemented on schedule and on budget.The five strategic projects that will be tracked are Staff Scheduling and Time Capture, Web Redevelopment, Laboratory Automation, HIS RFP/Health Care Tomorrow, and the cNEO Provincial Implementation.

Target: Target 2015/16: As per implementation schedule Perf. Corridor: 1=YES, 0 = NO

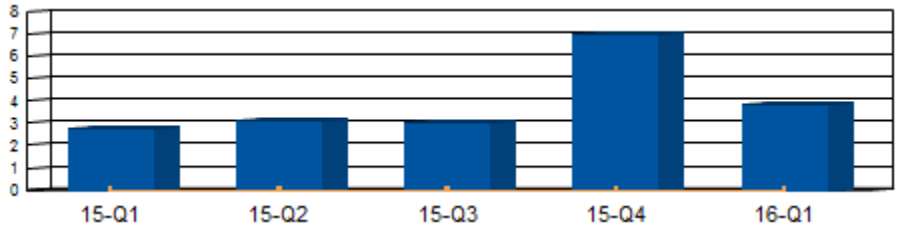
Kingston General Hospital

Q1 FY2016 Strategy Performance Indicators Report

Enable High Performance

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

Indicator: Total Margin (QIP)



	Actual	Target
15-Q1	2.77	**0**
15-Q2	3.08	**0**
15-Q3	2.99	**0**
15-Q4	7.03	**0**
16-Q1	3.86	**0**

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

Although greater than 0, the total margin through the first quarter of the fiscal year is slightly lower than planned. The same actions being undertaken to address the negative position to budget will impact the total margin calculation.

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

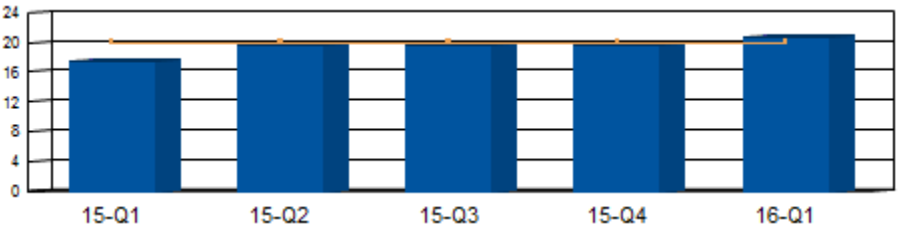
Are we on track to meet the target by year end? If not, what new tactics are planned to ensure the target is met?

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan EVP: Jim Flett REPORT: 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, Target 15/16: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

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



	Actual	Target
15-Q1	17.5	**20**
15-Q2	19.7	**20**
15-Q3	19.7	**20**
15-Q4	19.7	**20**
16-Q1	20.7	**20**

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

The hospital has achieved the total year target to maintain a $20 million capacity for capital spending with the inclusion of funding from the Ministry of Health and Long-Term Care Health Infrastructure Renewal Fund and estimated funding to be provided by the University Hospitals Kingston Foundation and the Kingston General Hospital Auxiliary.

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: J'Neene Coghlan COMMENTS: J'Neene Coghlan EVP: Jim Flett REPORT: SUPPORTING INDICATOR

Total amount available for capital investment. Calculated as net equipment amortization less long-term loan payments.

Target: Target 11/12: 12M, Target 12/13: 15M, Target 13/14: $17.5M Perf. Corridor: Red <$15M yellow $15M-$17.4M Green >=$17.5M,Target 14/15: $20M Perf. Corridor: Red <$15M yellow $15M-$17.4M Green >=$17.5M,Target 15/16: $20M Perf. Corridor: Red < $18 Million Yellow $18Million -< $20 Million Green >=>= $20 Million

Kingston General Hospital

Q1 FY2016 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