fiscal
2015 -2016 **Q2**

2nd quarter ended September 30, 2015

KGH this quarter

Strategy Performance Report

Kingston General Hospital

Outstanding care, always

KGH Strategy Performance Report Fiscal 2015 Q1

Strategic Direction 1

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

Outcome 1:

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

Strategic Performance Indicators

Outcome 2:

All preventable harm to patients is eliminated

Strategic Performance Indicators

Outcome 3:

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

Strategic Performance Indicators

KGH Strategy Performance Report Fiscal 2015 Q1

Strategic Direction 2

Bring to life new models of interprofessional care and education

Outcome 4:

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

KGH Strategy Performance Report Fiscal 2015 Q1

Kingston General Hospital

Q2 FY2016 Strategy Performance Indicators Report

Strategic Direction	2016 Outcome	Indicator	15-Q2	15-Q3	15-Q4	16-Q1	16-Q2	
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety, and service improvement initiatives	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	G	G	N/A	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	R	R	R	R	↓
		Hand Hygiene Compliance - (QIP)	R	R	R	R	Y	↑
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	R	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)	Y	R	R	R	G	↑
		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	Y	Y	↑
		Number of Incidents Associated with Morphine or Hydromorphone	G	Y	G	G	G	↓
		Number of Specimen Collection and Labelling Errors	R	R	R	R	Y	↑
	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	G	G	↑
		Percent ALC Days (QIP)	R	R	R	R	R	↑
		Overall Medical/surgical Occupancy Rate (Midnight Census)	R	Y	Y	G	Y	↑
		Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target	N/A	N/A	N/A	R	R	

Strategic Direction	2016 Outcome	Indicator	15-Q2	15-Q3	15-Q4	16-Q1	16-Q2	
	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	G	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	N/A	N/A	N/A	
		KGH Strategy Development Process Deliverables are met	N/A	N/A	N/A	G	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	G	G	
		Number of Staff with Performance Reviews and Agreements on File	R	G	G	R	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	G	G	
		The incidents of workplace violence injuries are reduced from 50 to 44 per year	N/A	N/A	N/A	R	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	N/A	N/A	Y	N/A	Y	↑
	Rapid transmission of information improves care and operational efficiency	Number of Strategic Technology Projects Implemented on Schedule	N/A	N/A	N/A	G	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 ↓

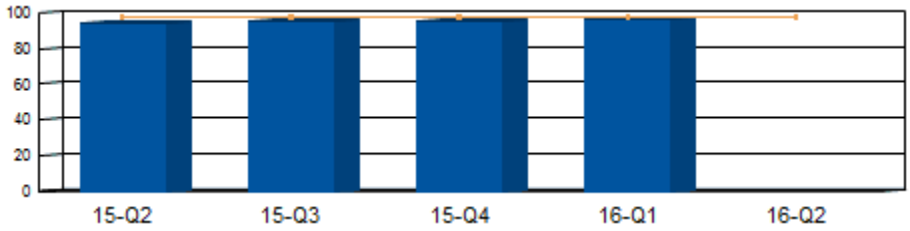
	Strategy					QIP					Supporting				
	FY15		FY16			FY15		FY16			FY15		FY16		
	Q3 %	Q4 %	Q1 %	Q2 %	Q2 #	Q3 %	Q4 %	Q1 %	Q2 %	Q2 #	Q3 %	Q4 %	Q1 %	Q2 %	Q2 #
R	44%	37%	37%	26%	7	67%	50%	50%	33%	4	34%	34%	39%	36%	27
G Y	56%	63%	63%	74%	20	33%	50%	50%	67%	8	66%	66%	61%	64%	48
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					27					12					75

Q2 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-Q2	94.0	**97**
15-Q3	95.0	**97**
15-Q4	95.0	**97**
16-Q1	96.7	**97**
16-Q2		**97**

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

KGH has licensed Communicate with H.E.A.R.T which is a service excellence program created by the Cleveland Clinic. Communicate with HEART uses a common sense approach of interacting with others. It's a healthcare-focused model that will provide all KGH staff, along with volunteers and physicians with the practical knowledge to help them address patient concerns. It will also help staff to communicate with patients, families and coworkers with empathy. By engaging our patients with consistent empathetic communication, we hope to address any concerns or question a 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. Training was revamped in Q2 to a hybrid delivery model using e-learning and in-class skills practice. Training resumes in Q3. Over 1100 staff, learners and volunteers have been trained since the course was introduced.

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

Most current reported performance is Q1 which sits at 97% which represents the target for fiscal 15/16.

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

Yes

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

Q2 FY2016 Strategy Performance Indicators Report

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

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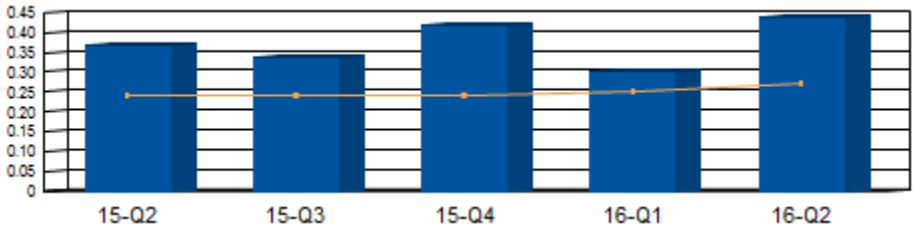
Indicator: C-Difficile (Reported Quarterly) (QIP)



	Actual	Target
15-Q2	0.37	**0.24**
15-Q3	0.34	**0.24**
15-Q4	0.42	**0.24**
16-Q1	0.30	**0.25**
16-Q2	0.44	**0.27**

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 preventing outbreaks. 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:

The KGH CDI rate for this quarter was 0.44 cases per 1000 patient days; a slight increase from Q1. The rate represent 15 cases this quarter, 5 cases more than last 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?

Target not met. We continue to quickly identify nosocomial clusters and implement additional measures to sustain the overall downward trend. KGH has now been 40 months without a CDI outbreak.
Tactics for 2015 - 2016 including ensuring the sustainability of the close collaboration between Programs and IPAC in identification and management of both suspect and confirmed cases of CDI; increasing awareness of the CDI Order Set and SOP's; and working with ES on daily cleaning or terminal cleaning procedures for patient's environment, equipment and bathroom.

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

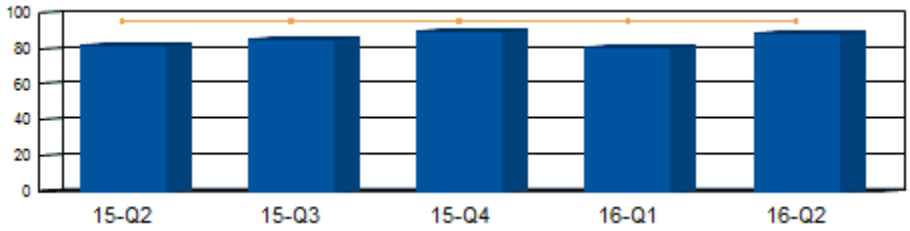
Kingston General Hospital

Q2 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: Hand Hygiene Compliance - (QIP)



	Actual	Target
15-Q2	82	**95**
15-Q3	85	**95**
15-Q4	89	**95**
16-Q1	81	**95**
16-Q2	88	**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 and roll out of changes are occurring. Ongoing support is available to auditors.
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:

The corporate HH rate for Q2 before moment was 88%, an increase from 81% achieved in Q1; the after moment was 94%. These rates are the reflection of 4,453 total observed opportunities of 3,408 healthcare workers.

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

The target of 90% compliance was not met, however there was a noted improvement over Q1. Efforts within the Programs and from IPAC Service to support auditors contribute to this improvement. The further roll out of the new Resource Tool and the "Just in Time" intervention training and education supported by The Hand Hygiene Working Group (HHWG) will contribute to further improving compliance rates. A new LMS module on hand hygiene is being finalized and will be rolled out corporately to all staff and physicians.

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%

Q2 FY2016 Strategy Performance Indicators Report

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

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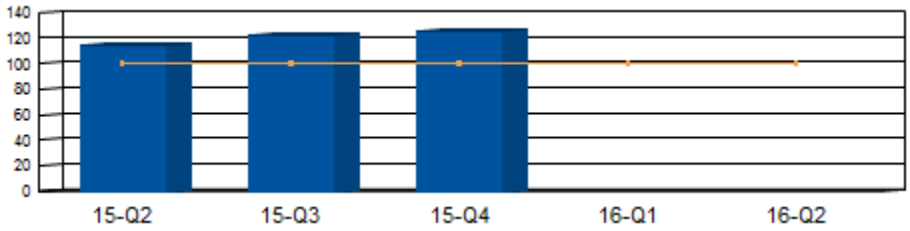
Indicator: Hospital Standardized Mortality Ratio (HSMR) (QIP)



	Actual	Target
15-Q2	115	**100**
15-Q3	122	**100**
15-Q4	126	**100**
16-Q1		**100**
16-Q2		**100**

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

Despite the fact that we have not yet received the most recent data form CIHI (Q1 and Q2 due in February) efforts are underway to improve the completeness and accuracy of our diagnosis and diagnosis type coding and abstraction from the medical chart. Chart audits from the Q3 and Q4 data suggest that compared to our peers we are not coding to the same level of specificity. Beginning in Q1 of this year, our medical records department has undertaken a very thorough review to ensure our procedure, diagnosis, and diagnosis type coding and abstraction is as complete and accurate as possible. Next steps are to work closely with physicians and other providers to improve the quality and accuracy of charting.

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

Q1 and Q2 results will not be made available from CIHI until February 2016 (Q3).

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

It is assumed with the improvements to charting accuracy and completeness the target will be met by year end.

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

Kingston General Hospital

Q2 FY2016 Strategy Performance Indicators Report

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

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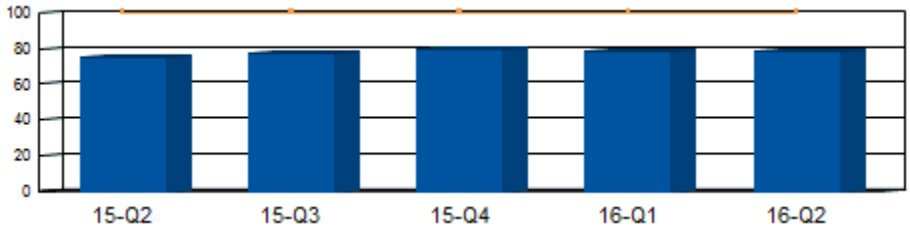
Indicator: Medication Reconciliation at Admission (QIP)



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

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

Fiscal 2015-16 Integrated Annual Corporate Plan Tactic to implement a prescriber education program for medication reconciliation started in October 2015. Pharmacy presented to the surgical residents (Orthopedics, General Surgery and Urology residents) on the process of medication reconciliation on admission.

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 remains steady at 78% in F16 Q2.

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

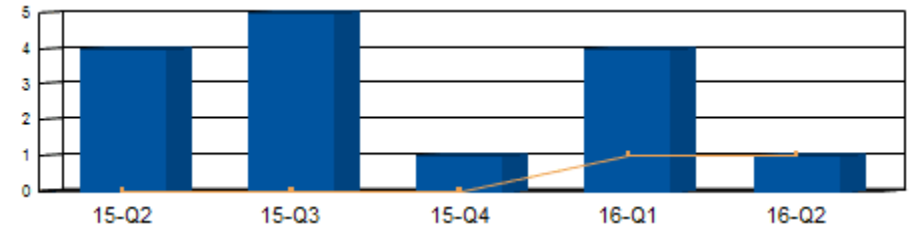
Development of a medication reconciliation policy in progress.
Admission order sets continue to be developed/updated to include the medication reconciliation process.

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%

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



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

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

Surveillance and risk assessments on 3 pilot inpatient unit continues with good results. Identification of patients and risk of falls therefore is beginning to achieve target levels in these areas. In Q3 and Q4 planned interventions include increasing the consistency of mobility plans and risk reduction strategies.

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

We have seen a result in the quarter equal to target. A positive improvement from the previous 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?

We are on target to complete the interventions described and are aiming to achieve average rates as planned.

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 and average of 3 to 1 per quarter.

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

Q2 FY2016 Strategy Performance Indicators Report

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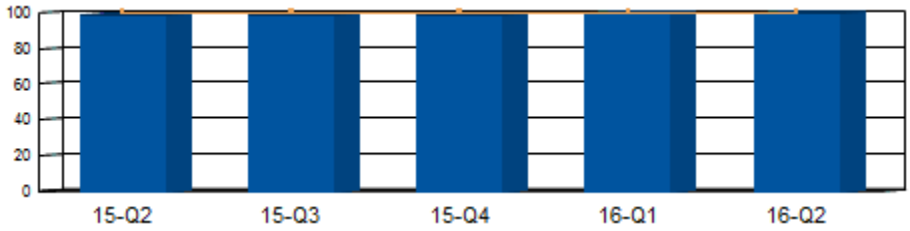
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



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

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

The monthly review of the Surgical Safety Checklist metrics by the Program council and at OR staff meetings 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 the second quarter this indicator continues to meet the green target corridor. There were 2,293 patients were received surgery been July and September. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 100%, Timeout-99.9%, and Debrief- 99.8%. There was only one emergent Plastics surgery case that did not complete the surgical safety check list that influenced this target.

The Connell 5 Labour & Delivery Operating rooms completed 121 caesarean sections this quarter. Their compliance for the checklist was the following: Brief-100%, Timeout-99.2% and Debrief-98.3%. There were two emergency cases that did not complete all three phases.

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

Q2 FY2016 Strategy Performance Indicators Report

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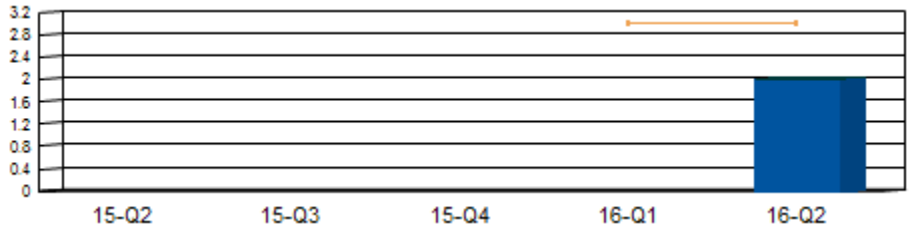
Indicator: Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)



	Actual	Target
15-Q2		
15-Q3		
15-Q4		
16-Q1		**3**
16-Q2	2	**3**

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

This quarter, new bed surfaces were introduced, initial education for the targeted units regarding skin assessment as well as a general increased awareness regarding the need for skin assessment through audit and feedback with monthly publication of unit success and care plan development through point of care decision support were tactics used to reduce the prevalence of pressure ulcers in our patient population.

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

To demonstrate a reduction in pressure ulcers in our targeted units of K2ICU, K6 and C10 the data obtained in the February 2014 Pressure ulcer Prevalence Study was used as the initial indicator. Prevalence studies have been done in each of the units on a monthly basis. Please note that the number of patients assessed changes due to census and bed mapping. K2ICU had 14/30 patients (47% prevalence) identified with pressure ulcers in Feb /14. A twenty five percent reduction would equal 3.5 fewer patients per prevalence study or a prevalence rate of less than 35%. The monthly data shows a reduction to 9/28 patients (32% prevalence) in July, 8/30 patients (27% prevalence) in August and 10/31 patients (32% prevalence) in September, with an average prevalence rate of 30.3% for Q2. Using Feb/14 as baseline data 15 fewer patients experienced pressure ulcers on K2 during Q2, exceeding target.

K6 had 9/33 patients (27% prevalence) identified with pressure ulcers in Feb/14. A twenty five percent reduction would equal 2.25 fewer patients per prevalence study or a prevalence rate of less than 22%. The monthly data shows 3/24 patients (16% prevalence) in July, 5/27 patients (18.5% prevalence) in August and 6/27 patients (22.2 % prevalence) in September, with an average prevalence rate of 19% for Q2. Using baseline data, 7 fewer patients experienced pressure ulcers on K6 during Q2, which met target.

C10 had 8/23 patients (35% prevalence) identified with pressure ulcers in Feb 2014. A twenty five percent reduction would equal 2 fewer patients per prevalence study or a prevalence rate of less than 27%. The monthly data identified 8/31 patients (26% prevalence) in July, 10/28 patients (36% prevalence) in August and 6/31 patients (19% prevalence) in September with an average prevalence of 27% for Q2. Using baseline data, 5 fewer patients experienced pressure ulcers on C10 during Q2 which was just short of our target.

While all of the areas have experienced a reduction in pressure ulcers based on the Feb/14 baseline data, we have only met our targets on two of the units. Continued vigilance to this issue will be needed to both sustain our progress and continue to improve.

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 target to meet our goals for year-end but will require a relentless focus on this indicator to continue to succeed. Third quarter we are rolling out LMS across the entire organization for nursing, we are developing skin champions with a full day of education for these nurses in November. The skin champions have self-identified their interest and have committed to being champions on the units. The targeted units are also receiving weekly in servicing, with weekly education posters going to the entire organization. A Heel ulcer working group was created to target heel pressure ulcers (2nd most prevalent ulcer type), and will meet in Q3. Audit and feedback of risk assessment completion, development of care plan for those at risk and audit of documentation continues with these tools being introduced across the organization. Measurement of the three targeted units continues to be a focus, but tactics are also being introduced across the organization to enable sustainment of these targets for all of our patients.

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.

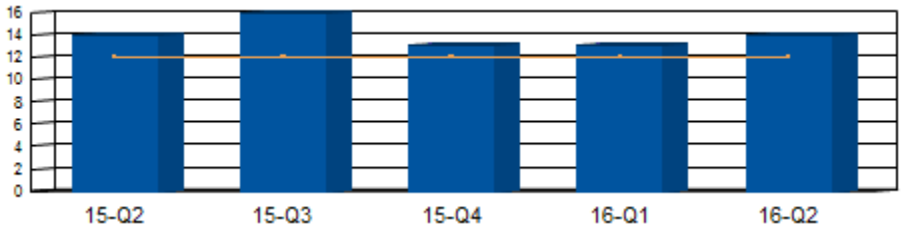
Target: Target 2015/16: 25% reduction Perf. Corridor: Red 1 or no units achieve Green Status, Yellow 2 units achieve Green Status, Green 3 of 3 units achieve green status

Q2 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: Number of Incidents Associated with Morphine or Hydromorphone



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

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

High-Alert list and safeguards for Controlled Drugs approved by the Pharmaceuticals and Therapeutics Committee with implementation planned for November 16, 2015

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

In Fiscal 2015-16 Quarter 2 (July 1 to September 30, 2015), there were 14 reported morphine and hydromorphone medication administration incidents. This is above the improvement priority target of 12 for this quarter.
Out of the 14 reported medication administration incidents, three involved morphine and 11 involved hydromorphone. There was one incident involving morphine administered when hydromorphone was ordered, and one incident involving hydromorphone being given when morphine was ordered. Of note, the two incidents were not related to the incorrect removal of the medications from the Automated Dispensing Cabinets (Omnicells); both incidents were related to Medication Administration Record (MAR) transcription errors.
The other administration incidents included incorrect dose/strength, incorrect formulation, incorrect medication and omissions. Most omission incidents involved PCA pumps.

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

The Hospital is on track to meet target by end of Fiscal year.
The implementation of the high-alert medication list including safeguards will support the safe administration of high-alert medications including morphine and hydromorphone and should help reduce the number of medication incident involving the selection of the incorrect formulation. In F16 Q3 the Medication Safety Committee will undertake a review of medication incidents related to transcription errors.

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

Q2 FY2016 Strategy Performance Indicators Report

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

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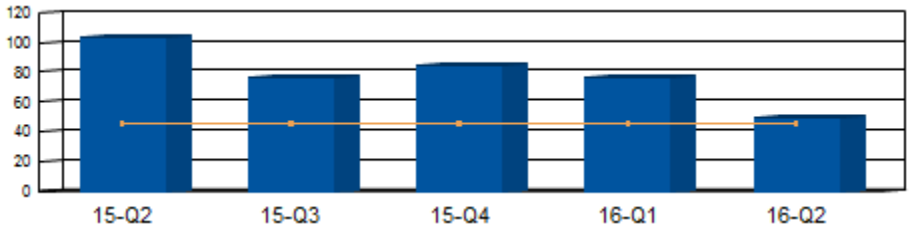
Indicator: Number of Specimen Collection and Labelling Errors



	Actual	Target
15-Q2	104	**45**
15-Q3	76	**45**
15-Q4	84	**45**
16-Q1	76	**45**
16-Q2	50	**45**

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

Results continue to trend in the right direction. Indicator has moved from red to yellow. Several tactics helped achieved this result including the roll out of EDIS in the Emergency department, the further roll out of the phlebotomy team and with targeted education on a unit with higher than expected incidents of specimen collection errors.

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

Laboratory results help care providers make clinical decisions around hospital admissions, discharges or medications. When a specimen is collected for laboratory testing and the specimen is not labelled or corrected properly rework or additional diagnostic testing is required. This may result in unnecessary lengths of stay or additional unnecessary health care costs.

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

Yes, we are on track to meet the target of 45 specimen collection errors per quarter. We will continue to identify units with higher than expected incidents of specimen collection errors and will work collaboratively with the units to bring the errors down.

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.

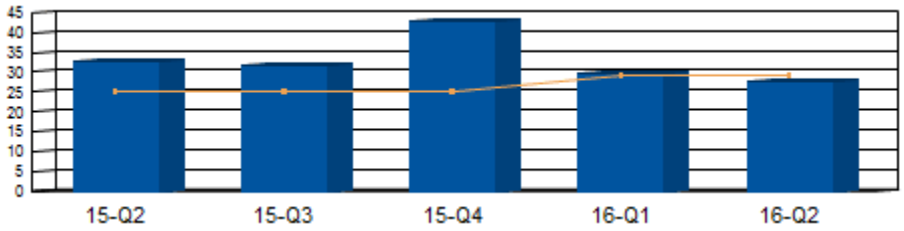
Target: Target 2014/15: 45 Perf. Corridors: Red >75. Yellow 56-75 Green <=55,Target 2015/16: 45/qtr. Perf. Corridors: Red >55/qtr. Yellow 46-55/qtr. Green <=45/qtr.

Q2 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-Q2	32.6	**25**
15-Q3	31.6	**25**
15-Q4	42.7	**25**
16-Q1	29.7	**29**
16-Q2	27.5	**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 in Q1, in Q2 the focus has been on sustaining gains made and identifying further opportunities to reduce bed empty time which will result in a reduced ED LOS for patients who are admitted. This includes earlier discharge times, earlier indication of bed ready flag, and trial of a surge protocol. The Patient Flow Task Force, which has representation from across all programs and services as well as CCAC, HDH 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 Q2 result of 27.5 hours below the 29 hour target. Based on Q2 admission volumes of 2802, 252 patients waited more than 27.5 hours in the ED for an inpatient bed. Admission rate from the ED is 19.3% in Q2 which is higher than the average Ontario teaching hospital rate of 15.2%. 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 = 22.5, HHSC = 25.5, SMH = 22.2, SHSC = 25.9, TOH = 27.6, TBRHC = 27.2, teaching hospital group 25.6. 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 55 for current performance and 63 for improvement out of 74 hospitals as of the end of August (based on the calendar year).

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

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

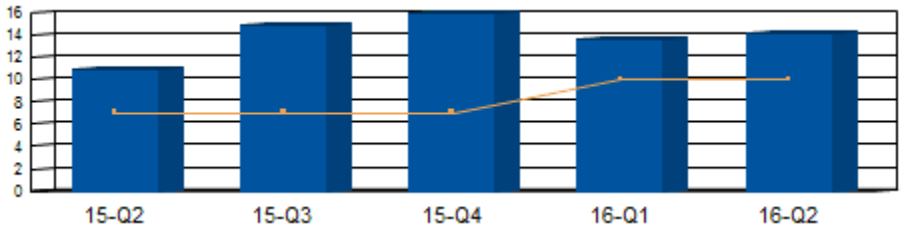
Kingston General Hospital

Q2 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-Q2	11.0	**7**
15-Q3	14.8	**7**
15-Q4	16.0	**7**
16-Q1	13.7	**10**
16-Q2	14.2	**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 patient flow coordinator is 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: Discharge Policy (including escalation process); Patient Transfer to Supportive Care Settings Policy; Alternate Level of Care Policy; Alternate Level of Care Co-Payment Policy; and Patient Repatriation.
- 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 Q1 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 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 & Q2, the Patient Flow Peer Group visited each hospital in the SE to bring forward recommendations to drive change and improvement based on best practices in place across the region. An action plan will be developed in Q3 to address opportunities for improvement.

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 Q2 result of 14.2% indicates that, on average, there were more than 55 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. A Home First refresh is planned for Q3.

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.

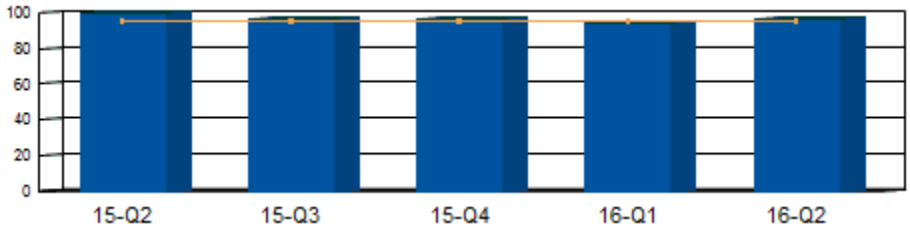
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q2 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-Q2	100	**95**
15-Q3	96	**95**
15-Q4	96	**95**
16-Q1	94	**95**
16-Q2	96	**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 Q2 overall medical/surgical occupancy rate increased to 96% this quarter. Whilst overall length of stay rates continue to be positive, total volumes of patients have risen in Q2 this is the driver for the increase in occupancy. There continues to be variation between the occupancy rates of the clinical programs and as such, high occupancy rates are now seen on most Medicine and Surgical floors, in previous quarters surgical occupancy was lower.

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.

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%

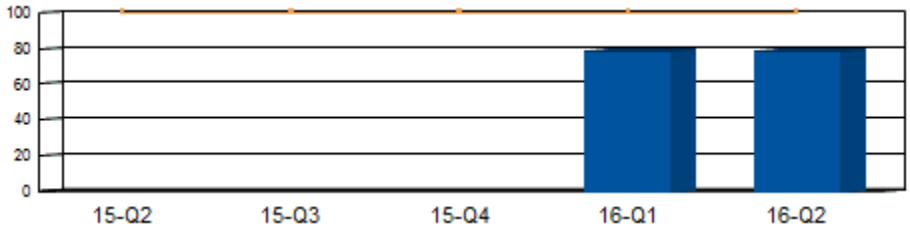
Kingston General Hospital

Q2 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 of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target



	Actual	Target
15-Q2		**100**
15-Q3		**100**
15-Q4		**100**
16-Q1	78	**100**
16-Q2	78	**100**

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 category. The denominator consists of 58 surgical categories, 2 diagnostic imaging (DI) categories and 3 cardiac categories. Priority 4 cases within 45 of the 58 (78%) surgical categories meet their target threshold. The breakdown of the 13 that did not is as follows: 2 Gen Surg, 1 Gyn Surg, 1 Neuro Surg, 3 Ortho Surg, 1 ENT, 1 Plastic Surg, 4 Urol surg. Of the 2 DI categories MRI priority 4 cases did not meet the 80% target, the CT priority 4 cases did. Of the 3 cardiac categories, all 3 meet the 80% target. Therefore, overall 49 of 63 (78%) clinical categories meet the 80% or greater priority 4 wait time target.

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

Yes. This indicator is 2 categories away from turning yellow. 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. Patients are assigned a priority score from 1 to 4 with 4 being the least urgent or most elective. Each priority score is assigned a target wait time by the MoH. For cases that fall into the priority 4 category a calculation of the percent of cases meeting that target wait time is done. The MoH has stated that hospitals should be meeting target wait times 90% of the time. This corporate indicator rolls together 63 various clinical categories to report overall adherence to the 90% target. It is intended to provide an overall view of progress with respect to meeting MOH wait time targets.

Target: Target 2014/15: 100% Perf. Corridors: Red <80% Yellow 80% - 90% Green 90%+,Target 2015/16: 90% days Perf. Corridors: Red <80% Yellow 80% - 90% Green 90%+

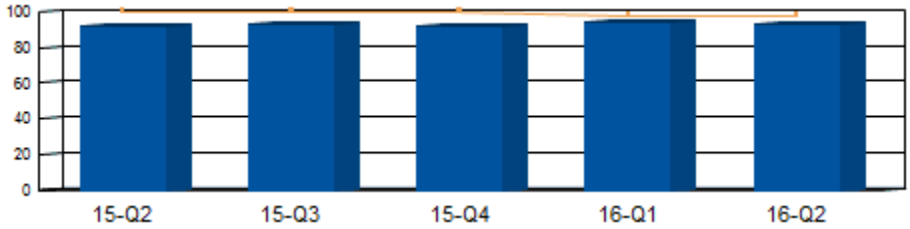
Kingston General Hospital

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

In July, August and September a total of 7559 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those total audits 7040 were in compliance or 93%. The individual standards are being reported at a corporate compliance rate of at least 90%. (Badges 90%, whiteboards 92%, Communication 96%, 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 5.
The standard for ID badges to be visible and worn at chest level by all staff and physicians is supplemented by our Vendor Management System (VMS). The VMS ensures that everyone who has official business in the hospital has ID available to them and must be wearing it. As the ID standard holds an expectation that everyone including vendors will have official ID it increases safety and security.

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

I have every confidence the standards for Whiteboards, Communication, Hourly Rounding and Feedback Forums can achieve the goal of 98%. ID badges will be more difficult as Physician compliance rate is at 65% for the 2nd quarter with Staff having a 95% compliance rate; together they generate 90% overall compliance. At this time if we continue to group physician compliance with the staff I don't see how we can meet the goal of 98%. The appropriate people have been made aware of the poor physician compliance and they continue to work at improving it.

Kingston General Hospital

Q2 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

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 98% 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%

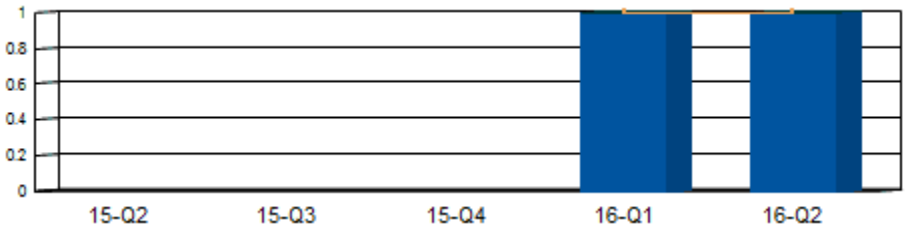
Kingston General Hospital

Q2 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-Q2		
15-Q3		
15-Q4		
16-Q1	1	**1**
16-Q2	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) has approved our Stage 3.2 (Sketch Plan Approval) for both Phase 1 and 2 of the Connell 4 project. We are currently preparing to submit Stage 4.1 (Pre-Tender Submission) documents to the MOHLTC in the third quarter. Staffs located on Connell 4 continually are being relocated over the next 1-2 quarters to ensure the area is vacant before construction commences.

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. Gordon Boyd's research into cardiac arrest is an example of how this commitment to research can have a profound impact on those individuals with critical illnesses. His appointment as a clinician scientist gives him the opportunity to integrate his front-line care of patients with his research, and ultimately translate that research into better care and better quality of life for his patients.

Dr. Gordon Boyd, an intensive care specialist and clinician scientist, is researching a puzzle. Why does a critical illness, such as cardiac arrest, affect the brain long after the rest of the body has healed? "Patients are released from ICU when they don't need breathing support, medication support, when their body seems to be working," says Dr. Boyd. "But we don't talk to them about how their brain is working. Right now there's almost no data about patients' recovery in ICU. We have no idea how well these people do after they leave the ICU or the hospital." Dr. Boyd is one of only two or three critical care physicians in Canada who is also a certified specialist in neurology. He is studying how the loss of blood and oxygen delivery to the brain, common effects of critical illness, can lead to worse performance while in intensive care, potentially affecting long-term neurological recovery. His research focuses on two patient groups: those undergoing cardiac surgery, and those suffering a critical illness such as septic shock. He will monitor patients while in intensive care, and then do follow-up assessments three, six and 12 months later using the KINARM, a robotic tool invented at Queen's University by a fellow neuroscientist, Stephen Scott. The KINARM is currently located in Connell 4 and will be in the new W.J. Henderson Centre for Patient Oriented Research. Data collected by the tool generates a valuable "fingerprint" of what the patient's brain impairment looks like. "Parts of the brain that handle sensory, motor and cognitive tasks are more susceptible to low blood pressure and low oxygen," says Dr. Boyd. "The KINARM is the perfect instrument for assessing these areas of the brain. I'm using it to identify the degree of dysfunction that these patients have, and correlating it to brain function."

This profile originally appeared in the Queen's Gazette and was 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?

We are still looking at 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. We are on track to meet our revised targets 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

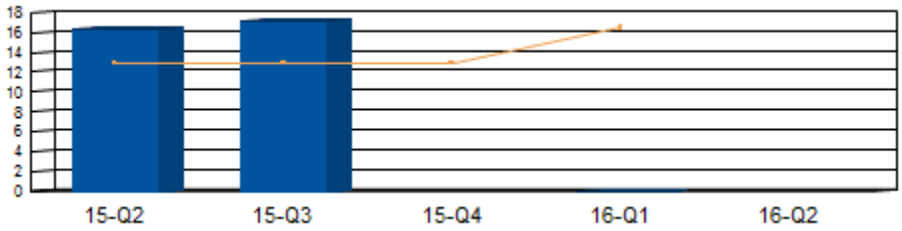
Kingston General Hospital

Q2 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-Q2	16.25	**12.9**
15-Q3	17.18	**12.9**
15-Q4		**12.9**
16-Q1		**16.47**
16-Q2		**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. Pharmacist-led project medication reconciliation at discharge is an 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 with 133 readmissions for the quarter. However, it is worth noting that this performance dates back to Q3 of last fiscal year. The current target (F15/16) which is based on and expected readmission rate is higher than previous year, therefore, the most recent Q3 data would be green by comparison. 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 exactly 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?

Note that the most recent data for Q3 F 14/15 against the current target would be green.

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.

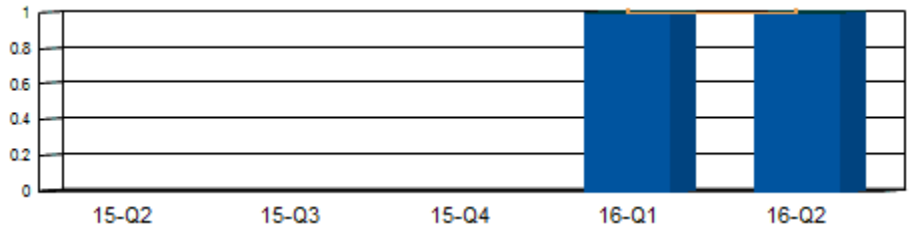
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected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

Q2 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-Q2		
15-Q3		
15-Q4		
16-Q1	1	**1**
16-Q2	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 and continue to conduct environmental analysis and stakeholder engagement through our internal forums and our work with the Health Care Tomorrow Hospital Services project. The tactics that have been implemented to date 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.
- Obtaining input from our Strategy Advisory Council related to the changes taking place in our organization and environment and their impact on KGH's future.

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 on schedule, we are progressing well towards the target of delivering the next long-term strategy for KGH. However, with the progress of Health Care Tomorrow and the changes that are currently taking place within our regional health care system, we may adjust the timing of our strategy delivery.

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

We are currently revising the scope and timing of the deliverables associated with meeting this target to align with the progress of Health Care Tomorrow and the changes taking place in our regional health care system. In the remaining quarters of this fiscal year, we will finalize our plans for phase two of our strategy development process, including the timing of our next long-term strategy, while continuing to participate in the Health Care Tomorrow Hospital Services project.

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)

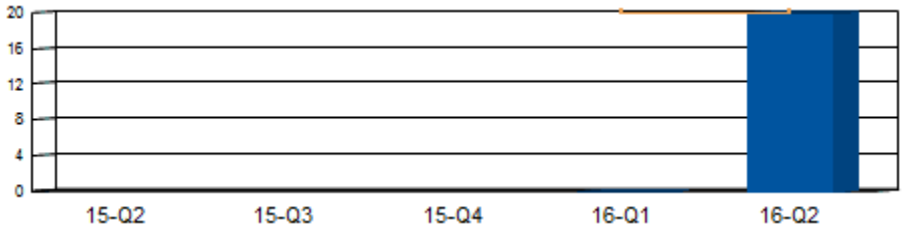
Kingston General Hospital

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

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

Leadership Development was an area of focus including participants in leading a Mentally Healthy Workplace Certificate program, Rotman Advanced System Leadership, Harvard ManageMentor online modules, and the roll out of LIFT which includes frontline and emerging leaders training. Another Frontline Leadership cohort began and access to the LEADS competency assessment was rolled out to all staff. The Hospital Liaison Committee for medical students continued and an agreement with Providence Care to bring in Library Services was reached.

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?

The staff and physician engagement survey will take place in November alongside the volunteer survey. An infographic was developed to focus on improvements to the 4 areas of corporate focus including education, training and learning. Meetings with leaders and information through KGH publications will further inform of progress made and encourage continued participation in the survey.

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

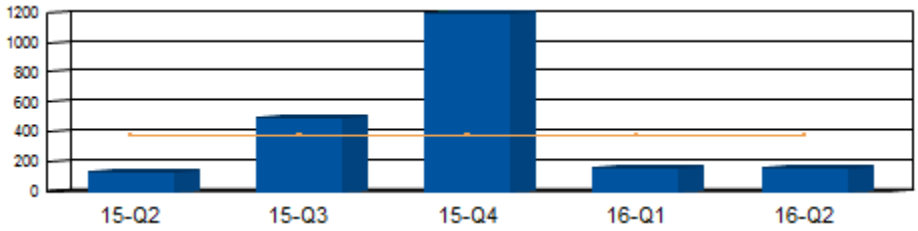
Kingston General Hospital

Q2 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-Q2	132	**375**
15-Q3	495	**375**
15-Q4	1,198	**375**
16-Q1	158	**375**
16-Q2	159	**375**

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

There were 317 completed performance plans at the end of the quarter. The non-union annual performance agreements completion was moved into quarter 2. The numbers for Q2 are largely driven by the non-union group. Information and training sessions took place for leaders and 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:

Performance conversations are linked to individual engagement and accountability. The emphasis on development and learning supports improved commitment of staff and continuous improvement. The KGH strategy emphasizes staff engagement, accountability and learning. The performance target was 1500 in each of 2 years for a 3000 total. Last year, 2084 were already completed.

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

Communication to leaders to emphasize target and completion rate through written leadership exchange, face to face through the XChange meetings, and via individual dashboards for each area to give a status update for completion. Given the link to engagement it will also form part of the engagement discussions which is a major area of focus in Q3 and Q4. The completion rate is following a similar pattern as last year whereby the majority of activity was in the last 2 quarters of the year.

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

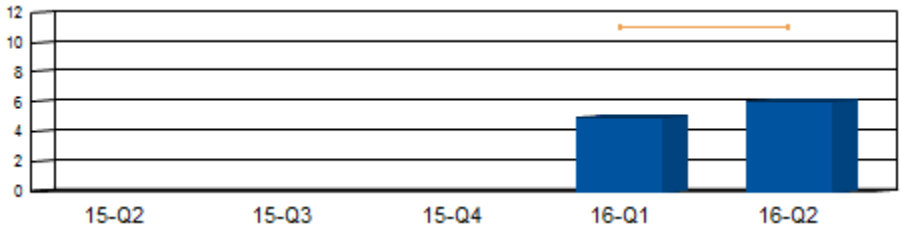
Kingston General Hospital

Q2 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-Q2		
15-Q3		
15-Q4		
16-Q1	5	**11**
16-Q2	6	**11**

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

4 of the 6 claims occurred in the medicine program.
Of the 6 claims, one (1) resulted in lost time and 5 resulted in WSIB health care claims.
5 of the 6 claims occurred in September. New capital equipment (e.g. high-low beds, mechanical lifts) along with support from Ergonomist in providing training and working with units to ensure proper equipment in place have been the focus 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:

Continued good performance this quarter with achieving fewer overall MSIs due to patient handling activities with a resulting fewer number of claims; while our goal this year is to see a 20% reduction, our year-to-date reduction is +40%.

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 target to reach our goal. In Q3, a risk assessment on patient handling will be finalized as part of the Safety Groups Program with a continuous improvement plan developed to address identified gaps. We will work with managers in Q3 to ensure all clinical staff completes the mandatory online Safe Patient Handling Training which is intended to support safe patient mobilization; currently the completion rate is 64%.

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.

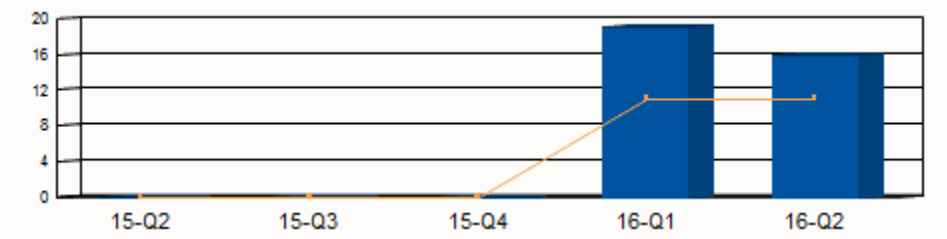
Target: Target 2015/16: 42 (11/qtr.) Red >47 (>13/qtr.), Yellow 43-47 (12-13/qtr.), Green <=42 (<=11/qtr.)

Q2 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-Q2		
15-Q3		
15-Q4		
16-Q1	19	**11**
16-Q2	16	**11**

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

Out of a total of 45 reported incidents of violence, 16 were reported to have resulted in staff injury; 50% of the reported injuries occurred in the Mental Health Program. Five (5) required no first aid/no treatment, eight (8) reported self-treatment, one (1) was a first aid incident, and two (2) resulted in WSIB health care claims.

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

Although we did not achieve our goal for a 20% reduction, our injuries resulting from violence were lower in Q2 as compared to 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?

At the current rate, it is unlikely we will meet our target. Activities undertaken to support this goal in Q2 included: the ongoing provision of Non-violent Crisis Intervention Training to staff in units at higher risk of violence (C3, C9, C10, ED, Burr 4, Kidd 7), violence risk assessments initiated in Q2 are nearly complete, an additional security position was approved and initiated in Q2, new patient search and gowning procedures are in place, debriefs are in place for code white events with physicians now required to attend them, violence risk assessments have been embedded in the clinical records of most inpatient areas, and the Workplace Violence Taskforce has developed an extensive action plan that is being worked on. With 13 of the 16 incidents involving patients who already had active Behavioural Crisis Alerts (BCAs) in place, our focus going forward needs to be on developing care plans (risk reduction plans) that prevent and better manage at risk behaviour. A Risk Reduction Plan is already in place in the Mental Health Program and is currently being trialed on Kidd 7 for possible reapplication throughout the hospital. E-Learning that will be launched by the end of Q3 will include content on care planning for patients at increased risk of aggressive/violence behaviour. For enhanced patient and staff safety, the ED will be installing card access to restrict access to the ED in Q3.

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.

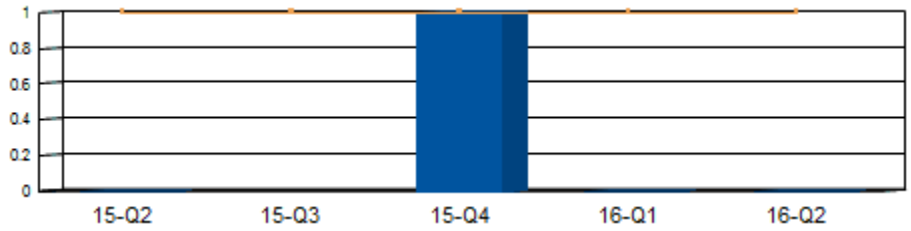
Target: Target 2015/16: 44(11/qtr) Perf. Corridor: Red >49(>13/qtr.), Yellow 45-49 (12-13/qtr.), Green <=44 (<=11/qtr.)

Q2 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-Q2		1
15-Q3		1
15-Q4		1
16-Q1		1
16-Q2		1

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

Since last quarter KGH hosted another tour for the MOH staff including James Stewart, Director, Health Capital Investment Branch. In addition several meeting were also held between senior hospital staff and Ministry executives to further advance the Ministry's understanding of the KGH Submission. We responded in writing to some of their questions around phasing of construction.

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

Unfortunately there has been no change in our status since last year when we made the Stage 1 submission. To date we understand the Ministry has not responded or approved any new projects advancing in the Capital Project Process. We have completed a high-level project plan outlining how we would proceed once approved, but currently our Phase 2 Project is therefore on hold an no new resources are being expended on the next stage 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?

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.

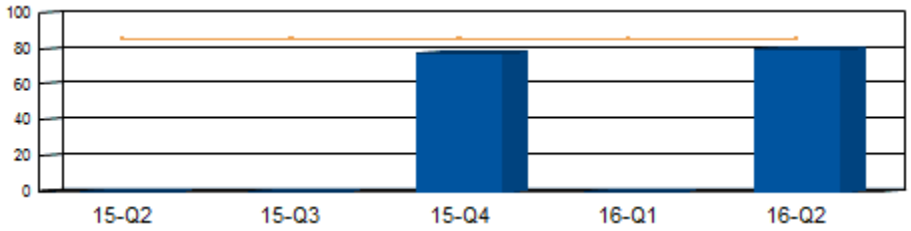
Target: Target 13/14 (1/0 = Yes/No) Perf. Corridor: Red No Yellow N/A Green Yes,Target 14/15 (1/0 = Yes/No) Perf. Corridor: Red 0 Yellow N/A Green 1(1 = Yes 0 = No),Target 15/16 (1/0 = Yes/No) Perf. Corridor: Red 0 Yellow N/A Green 1(1 = Yes 0 = No)

Q2 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-Q2		**85**
15-Q3		**85**
15-Q4	77	**85**
16-Q1		**85**
16-Q2	80	**85**

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

Improvement was noted in all risk categories when compared to the March 2015 Audit. Generally there was no erosion in quality except in the area of floor care where only 45% of floors were acceptable as opposed to 68% in the March audit. The most significant concerns were noted in the cleaning of beds/stretchers and furnishings/fixtures. Emergency Department, Endoscopy was two critical areas that scored well below the 85% benchmark and require immediate intervention.

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

Since the audit in July, there has been an increased focus in the Emergency Department i n several areas. First we have increased our management presence in this department with more frequent informal inspections of each area within ED identifying issues and resolving them immediately. Duty lists for the ED are currently being reviewed as well as ED activity in order to properly allocate and align our resources to be the most effective. Extensive effort has also been put forward with respect to floor care in the ED. More coordination with nursing will is requested as we move forward so that we can return the ED floors to the best condition possible. ICU duty lists have been revised and will be implemented as soon as they are reviewed and approved by unit managers. In addition, targeted training on cleaning procedures for patient beds and furniture has also been implemented and is anticipated to be fully completed by November 30th.

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

Other initiatives to improve quality and meet the target by the end of the year include: 1. A restructuring of the Environmental Services management team to improve supervision and training to be in place by January 4th, 2016, 2. Complete realignment of workloads and timing for all environmental services positions to be implemented by the end of January 2016, 3. Complete review of capital Equipment to make sure that we are maximizing technologies to achieve and exceed the 85% benchmark

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.

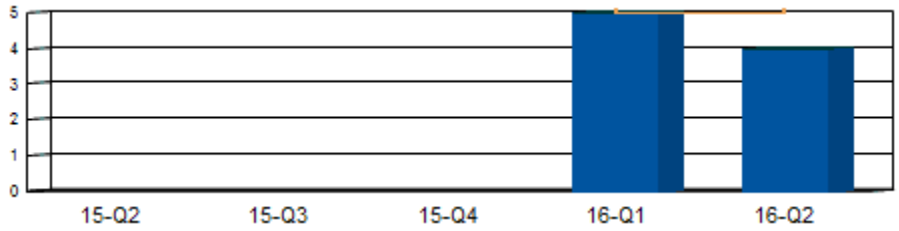
Target: Target 2012/13: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%,Target 2014/15: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%,Target 2015/16: 85% Perf. Corridor: Red <75% Yellow 75%-84% Green >=85%

Q2 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-Q2		
15-Q3		
15-Q4		
16-Q1	5	**5**
16-Q2	4	**5**

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

- The HIS RFP is currently awaiting direction from the Health Care Tomorrow project before significant progress can be made.
- The cNEO provincial project is on schedule with 3 of 7 hospitals ready for stage 2 execution at the end of Q3 (KGH, HDH & Brockville).
- The Automated Chemistry Track project is underway. The chemistry instruments will be implemented on November 29 however validation and device issues are being experienced which could affect timelines (risk mitigation is underway). The instruments can go-live on November 29 if risks are avoided. Chemistry track delivery is scheduled for mid-December with track installation to start on January 11 (6 week install).
- - The Web Redevelopment project experienced some schedule delays due to resource availability however a second phase of alpha testing is scheduled for completion by October 30 with Beta testing to begin on November 9. A Go Live date for full launch will be determined by November 13.
- The Staff Scheduling and Time Capture project is planning on continuing roll-outs over Q3 and Q4. At the time this report was released the project went into yellow status.

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 overall performance (the Web Redevelopment project did experience a 30 day delay due to resource availability however resources within the hospital are being re-aligned to support the project). 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?

Four (4) of the five (5) projects are on track for completion by the end of Fiscal 2016. The cNEO and HIS RFP projects will continue into Fiscal 2017 as planned.

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.

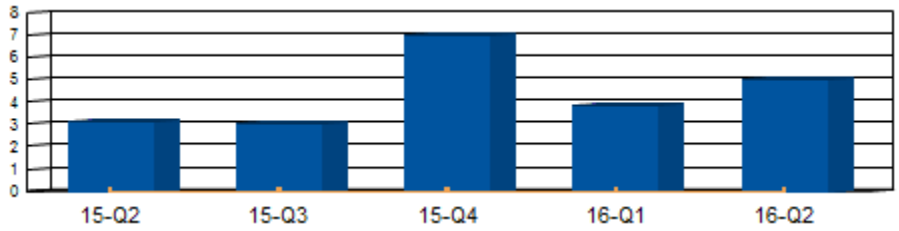
Target: Target 2015/16: As per implementation schedule Perf. Corridor: 1=YES, 0 = NO

Q2 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-Q2	3	**0**
15-Q3	3	**0**
15-Q4	7	**0**
16-Q1	4	**0**
16-Q2	5	**0**

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

The margin reflected at Q2 exceeds the budgeted performance 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:

The favourable position is mainly due to the recognition of one-time revenue/recovery and expense adjustments

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

At this point in time, senior leadership is optimistic that the hospital will achieve a balanced operating position. Monthly financial reporting and analysis support will continue to be provided monthly to allow those with budget responsibility to make informed decisions relative to actions necessary to ensure that year-end performance achieves a balanced budget position. High-level summary results by category continue to be provided to the KGH senior leadership team to inform discussion and decisions made by the hospital Planning and Performance Committee.

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

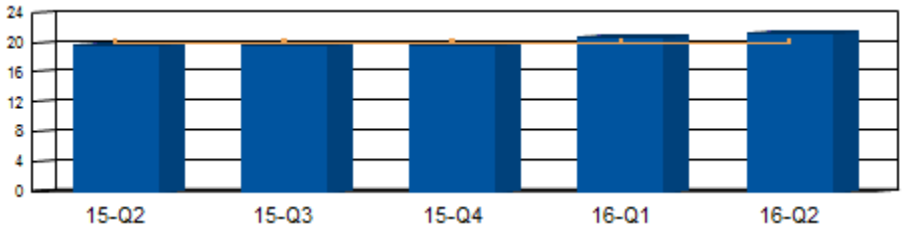
Kingston General Hospital

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



	Actual	Target
15-Q2	19.7	**20**
15-Q3	19.7	**20**
15-Q4	19.7	**20**
16-Q1	20.7	**20**
16-Q2	21.3	**20**

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

The hospital has exceeded 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 the Kingston General Hospital Auxiliary and estimated funding to be provided by the University Hospitals Kingston Foundation.

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

With the inclusion of funding from the Ministry of Health and Long-Term Care Health Infrastructure Renewal Fund and the Kingston General Hospital Auxiliary and estimated funding to be provided by the University Hospitals Kingston Foundation the hospital is generating a spending capacity of $21.3 million.

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

As the current year funding adjustment (reduction) has not yet been confirmed by the SE LHIN, senior leadership has put a hold on additional capital spending to ensure the ability to maintain the working capital position of the hospital.

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

Q2 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