fiscal
2015-2016 **Q3**

3rd quarter ended December 31, 2015

KGH this quarter

Strategy Performance Report

Kingston General Hospital

Outstanding care, always

KGH Strategy Performance Report Fiscal 2016 Q3

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 2016 Q3

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 2016 Q3

Kingston General Hospital

Q3 FY2016 Strategy Performance Indicators Report

Strategic Direction	2016 Outcome	Indicator	15-Q3	15-Q4	16-Q1	16-Q2	16-Q3	
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety, and service improvement initiatives	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	G	Y	N/A	↑
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	R	R	R	G	↑
		Hand Hygiene Compliance - (QIP)	R	R	R	Y	Y	↑
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	R	R	N/A	N/A	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	R	Y	↑
		The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)	R	R	R	R	R	↓
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	G	G	G	G	G	↑
		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	Y	Y	Y	↑
		Number of Incidents Associated with Morphine or Hydromorphone	Y	G	G	G	Y	↓
		Number of Specimen Collection and Labelling Errors	R	R	R	Y	G	↑
	All preventable delays in the patient journey to, within, and from KGH are eliminated	90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)	Y	R	G	G	Y	↓
		Percent ALC Days (QIP)	R	R	R	R	R	↓
		Overall Medical/surgical Occupancy Rate (Midnight Census)	Y	Y	G	Y	R	↓
		Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target	N/A	N/A	R	R	Y	↑

Strategic Direction	2016 Outcome	Indicator	15-Q3	15-Q4	16-Q1	16-Q2	16-Q3	
	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	G	G	G	↑
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	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	G	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	G	G	G	↑
		Number of Staff with Performance Reviews and Agreements on File	G	G	R	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	G	G	G	↑
		The incidents of workplace violence injuries are reduced from 50 to 44 per year	N/A	N/A	R	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	Y	N/A	Y	N/A	↑
	Rapid transmission of information improves care and operational efficiency	Number of Strategic Technology Projects Implemented on Schedule	N/A	N/A	G	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 ↓

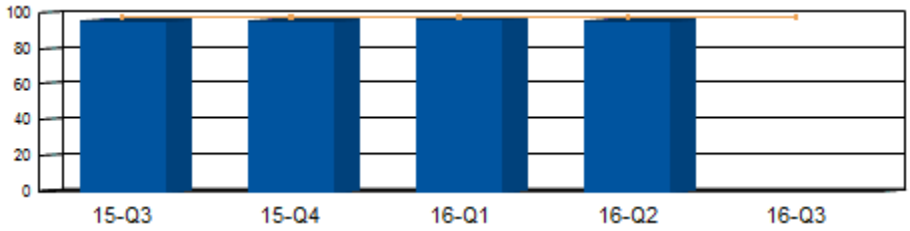
	Strategy					QIP					Supporting				
	FY15	FY16				FY15	FY16				FY15	FY16			
	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #	Q4 %	Q1 %	Q2 %	Q3 %	Q3 #
R	37%	37%	26%	22%	6	50%	50%	33%	25%	3	34%	39%	36%	28%	22
G Y	63%	63%	74%	78%	21	50%	50%	67%	75%	9	66%	61%	64%	72%	53
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					27					12					75

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

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

KGH has licensed Communicate with H.E.A.R.T which is a service excellence program created by the Cleveland Clinic. Communicate with HEART uses a common sense approach of interacting with others. It's a healthcare-focused model that will provide all KGH staff, along with volunteers and physicians with the practical knowledge to help them address patient concerns. It will also help staff to communicate with patients, families and coworkers with empathy. By engaging our patients with consistent empathetic communication, we hope to address any concerns or 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. 294 trainees completed the e-learning module in Q3 and 68 of those trainees completed the in-class skills practice. To improve sustainability, HEART training has been added to the inter-professional orientation to engage staff upon entry into the workplace.

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 Q2 which sits at 95% which is 2% below the current 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%

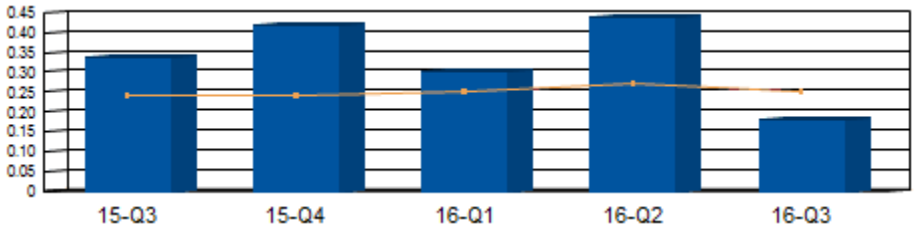
Kingston General Hospital

Q3 FY2016 Strategy Performance Indicators Report

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

All preventable harm to patients is eliminated

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



	Actual	Target
15-Q3	0.34	**0.24**
15-Q4	0.42	**0.24**
16-Q1	0.30	**0.25**
16-Q2	0.44	**0.27**
16-Q3	0.18	**0.25**

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

The tactic work plan for 2015-2016 continue current strategies implemented to prevent outbreaks including diligent surveillance by IPAC Service of all query and confirmed CDI cases; daily ICP presence on the units and in ED who work 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 lead to enhancing the reporting to IPAC of results including a lab generated 24 hour CDI report, pushed and printed in IPAC. Continued efforts between IPAC and Environmental Services to ensure appropriate use of sporicidal cleaners and prompt initiation of enhanced cleaning when clusters are identified.

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

In October there were 4 cases of CDI, in November there was 1 case and in December there were 2 cases for a total of 7 cases in Q3. This is 9 fewer cases than in 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?

On track to meet target by year end.

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.

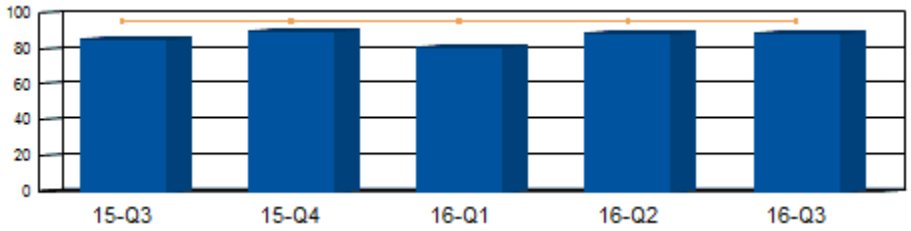
Target: Fiscal 2011/12 - QIP Goal = 0.30, QIP Target for Compensation = 0.77 Fiscal 2012/13: 0.3, Target 13/14: 0.37 Perf. Corridor: Red >0.42 Yellow 0.38-0.41 Green <=0.37, Target 14/15: 0.24 Perf. Corridor: Red >0.26 Yellow 0.25-0.26 Green <=0.24, Target 2015/16: 0.25 Red:>10% of Provincial Rate Yellow: Within 10% of Provincial Rate Green <= Provincial Rate

Q3 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-Q3	85.0	**95**
15-Q4	89.4	**95**
16-Q1	81.0	**95**
16-Q2	88.0	**95**
16-Q3	88.0	**95**

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

The tactic work plan for 2015-2016 continues, supporting new auditors, working directly with Programs, attending staff meetings to clarify Patient Environment vs. Hospital Environment. The Hand Hygiene LMS module has been finalized. 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:

Q3 average was 88%, sustaining the momentum achieved in Q2 (88%) improving from Q1 (81%). Total Opportunities observed increased in Q3 by 2,365 from 4,453 in Q2 to 6,818 in Q3.

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

We are on track to meet target.

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%

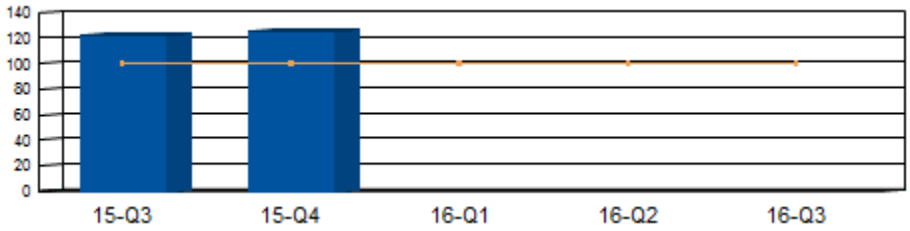
Kingston General Hospital

Q3 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: Hospital Standardized Mortality Ratio (HSMR) (QIP)



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

Q3 FY2016 Strategy Performance Indicators Report

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

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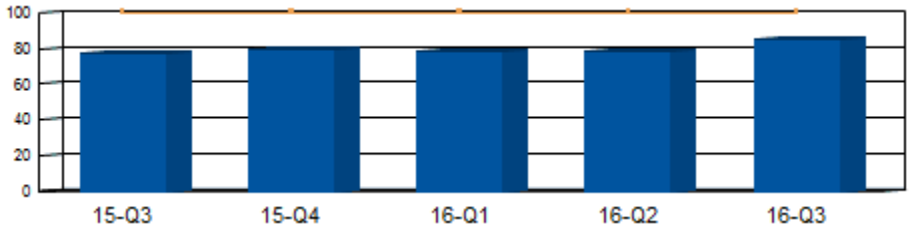
Indicator: Medication Reconciliation at Admission (QIP)



	Actual	Target
15-Q3	77	**100**
15-Q4	79	**100**
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	85	**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. Education to Surgical residents (Orthopedics, General Surgery and Urology residents) on the process of medication reconciliation on admission completed. MAC approved mandatory education for physicians. LMS module for all physicians in development by Pharmacy and Leadership and Learning.

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

The percentage of patients who receive medication reconciliation at the time of admission to the Hospital has increased to 85% in F16 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?

Unlikely to achieve target of 90% by F16 Q4.
Development of a medication reconciliation policy in progress.
Admission order sets continue to be developed/updated to include the medication reconciliation process.
Pediatric Surgical Admission Order set to be submitted to the Order Set Committee in February 2016.

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.

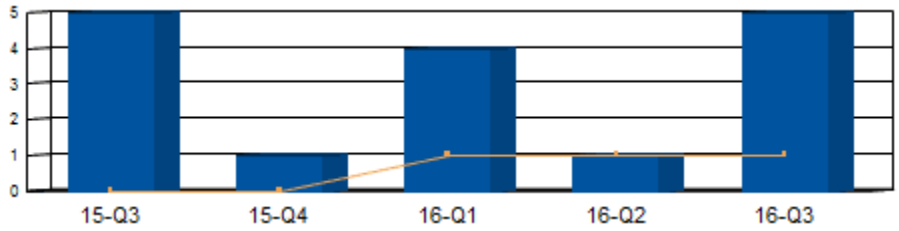
Target: Target 14/15: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%, Target 15/16: 100% Perf. Corridor: Red <= 80% Yellow 80%-89% Green >=90%

Q3 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: The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)



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

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

Surveillance and risk assessments processes are in place and available across the hospital as planned. Usage audits of these on sample units shows good levels of usage. The resultant assessments provide invaluable information to have available to the patients' care team in developing plans to mitigate risk and safely support early and continued mobilization of patients. In Q4 further improvement initiatives are being identified and planned.

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

We have seen 5 Level 3 falls in the quarter. Each incident was fully investigated at a program level and no particular causal factor was identified. Risk assessments were appropriately completed and mitigation strategies in place. The incidents occurred in different units, indicating no 'clustering'; in 3 of the 5 incidents the patient fell in the presence of staff or family member. This further highlights the potential for harm from any fall in circumstances where one would not particularly expect it.

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

Since tracking started, 3 of 7 quarters met the target we have set. Significant amounts of work and improvement, education and learning has taken place. We do continue to see falls occur and work continues to identify further improvements and supports to reduce frequency of all falls and thus the chance of a L3 or L4 occurring.

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.

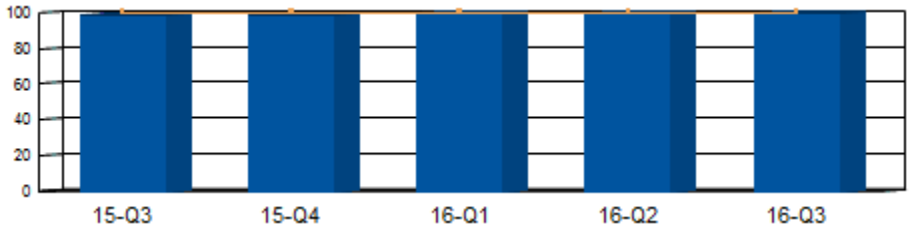
Target: Target 15/16: 1/qtr Red >3 Yellow 2-3 Green <=1

Q3 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: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



	Actual	Target
15-Q3	99.0	**100**
15-Q4	99.0	**100**
16-Q1	99.6	**100**
16-Q2	99.8	**100**
16-Q3	99.7	**100**

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

The Surgical Perioperative Anesthesia (SPA) program leaders continue to monitor the indicator on a monthly basis.

The Maternal Child program will be reviewing the surgical safety checklist processes with clinical staff to ensure that all 3 phases are electronically documented for each caesarean section.

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 continues to meet the green target corridor. There were 2,217 patients were received surgery been October and December. The main OR's compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.9%, Timeout-99.8%, and Debrief- 99.8%. There were three emergent surgery cases (1- Emergency A case, 2 Emergency B cases) that did not complete the surgical safety check list that influenced this target.

The Connell 5 Labour & Delivery Operating rooms completed 131 caesarean sections this quarter. Their compliance for the checklist was the following: Brief- 98.5%, Timeout-96.9% and Debrief-96.9%. There were 3 scheduled and 4 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 the 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.

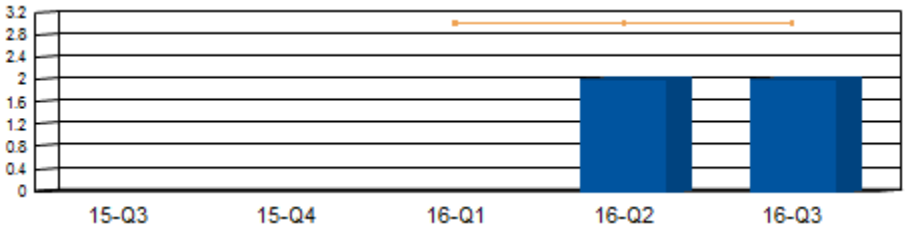
Target: Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%, Target 15/16: 100% Red <85% Yellow 85%-94% Green: >95%

Q3 FY2016 Strategy Performance Indicators Report

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

All preventable harm to patients is eliminated

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



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

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

This indicator remains yellow but is only 2% away on one unit to obtain green status. This quarter has been heavily invested with education for front line providers. LMS released with 50% of front line nursing staff having completed the module. Face to face education continues and education and development of skin champions has started. 50 skin champions attended an all-day education event with excellent feedback. Working group about heel ulcers (2nd most common type of pressure ulcer) met and forwarded recommendations.

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

We continue to focus on the three targeted units, K6, C10 and K2ICU.

For K6, 2/25 pts experienced pressure ulcers with a prevalence rate of 8% in October, 2/28 pts experienced pressure ulcers with a prevalence rate of 7% in November, and 2/25 pts experienced pressure ulcers with a prevalence rate of 8% in December with a quarterly average pressure ulcer prevalence of 7.7% (goal of 20.5% pressure ulcer prevalence rate). This unit has performed beyond expectations this quarter and has prevented 18 patients from developing a pressure ulcer this quarter

For Connell 10 9/29 pts had pressure ulcer with a prevalence rate of 31% in October, 6/31 patients had a pressure ulcer with a prevalence rate of 19% in November and 7/27 pts had a pressure ulcer with a prevalence rate of 26% in December . The average quarterly prevalence rate was 25% (target 27%) This unit has also met target and prevented 4 patients from developing pressure ulcers this quarter.

K2ICU had 11/26 patients with a pressure ulcer with a prevalence rate of 42% in October, 8/27 patients with a prevalence rate of 19% in November and 11/27 pts with a prevalence rate of 41% in December. The average quarterly prevalence rate is 37.5% (target 35%) This unit is just shy of target, but compared to the February 2014 data, they still prevented 2 patients from developing pressure ulcers.
The work done has collectively prevented 24 pressure ulcers for our patients on these three units this quarter compared to February 2014 data.

This indicator is very close to target, and education has been cornerstone of this quarters work. Strategies have been put in place to assist K2ICU to meet target for the next quarter; these include enlisting an ICU physician to champion the skin imitative and review of ICU documentation and assessment tools.
Moving forward, we will continue to educate with a focus on the patient care assistant (PCA). This class of unregulated care provider is performing many of the day to day personal care for patients, and has not been included in the initial education. This quarter we will also be participating in the Hill-Rom international Pressure Ulcer Prevalence Survey for the first time. This will allow KGH to benchmark with other organizations across Canada, and use of this yearly survey will provide yearly data to ensure we sustain our progress. The newly trained skin champions will be trained and utilized for this survey giving us a continued group of staff who can continue to provide this service.

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

We are on track to meet this target. Documentation tools have been addressed for those areas that were lacking and education continues to occur, including education for patient care assistants.

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

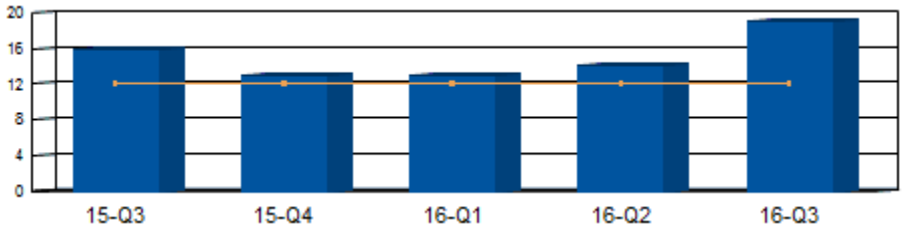
Kingston General Hospital

Q3 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-Q3	16	**12**
15-Q4	13	**12**
16-Q1	13	**12**
16-Q2	14	**12**
16-Q3	19	**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 Automated Dispensing Cabinets alerts in place.

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

n Fiscal 2015-16 Quarter 3, there were 19 reported morphine and hydromorphone medication administration incidents.
This is above the improvement priority target of 12 for this quarter.
Out of the 19 reported medication administration incidents, six involved morphine and 13 involved hydromorphone. There was one incident involving morphine administered when hydromorphone was ordered, and one incident involving hydromorphone being given when morphine was ordered. Incorrect frequency of administration was the most common type of incidents.

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 startedev 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

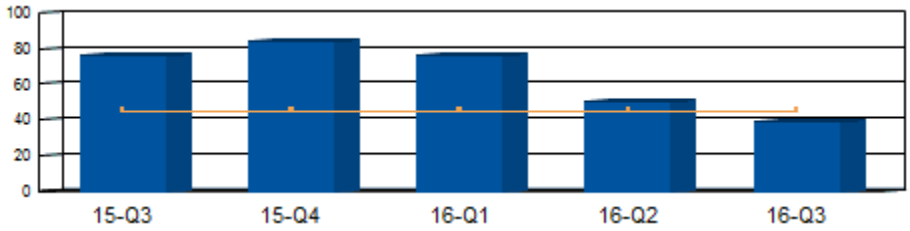
Kingston General Hospital

Q3 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 Specimen Collection and Labelling Errors



	Actual	Target
15-Q3	76	**45**
15-Q4	84	**45**
16-Q1	76	**45**
16-Q2	50	**45**
16-Q3	39	**45**

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

The indicator has moved from RED to YELLOW to now GREEN. There are many things that have contributed to reaching the target of less than 45 specimen collection errors per quarter. The combination of using technology, using the SAFE reporting tool, working collaboratively with other stakeholders, the introduction of the phlebotomy team and working closely with the Patient Relations and Quality Advisors all have contributed to the success of reaching this goal.

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

80% of all medical decisions are based on laboratory results. Laboratory results are used to diagnose, screen or monitor disease states. Admissions, discharges and medications are based on laboratory results so it is imperative that the sample collected is on the right patient and that the sample is labelled correctly.

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 indicator has moved from RED to GREEN. Due to upcoming technology and laboratory equipment changes it is imperative that specimens continue to come into the laboratory correctly labelled.

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.

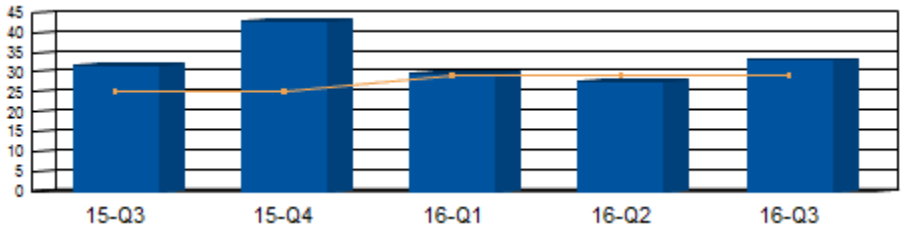
Target: Target 2014/15: 45 Perf. Corridors: Red >75. Yellow 56-75 Green <=55,Target 2015/16: 45/qtr. Perf. Corridors: Red >55/qtr. Yellow 46-55/qtr. Green <=45/qtr.

Q3 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-Q3	31.6	**25**
15-Q4	42.7	**25**
16-Q1	29.7	**29**
16-Q2	27.6	**29**
16-Q3	33.0	**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 & 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 Q3 result of 33 hours is above the 29 hour target. Based on Q3 admission volumes of 2805, 252 patients waited more than 32.9 hours in the ED for an inpatient bed. Admission rate from the ED is 20.1% in Q3 which is higher than the average Ontario teaching hospital rate of 15.6%. 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 = 19.8, HHSC = 29.2, SMH = 24.2, SHSC = 27.6, TOH = 26.2, TBRHC = 28.4, teaching hospital group 27.3. We are 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 November (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 and expedited movement out of the ED after decision to admit.

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.

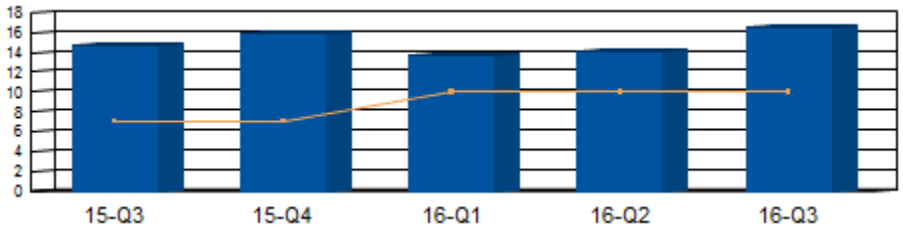
Target: Target 11/12: 31 Hours, Target 12/13: 22 Hours, Target 13/14: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 14/15: 25 Hours Perf. Corridor: Red >31 Yellow 28-31 Green <28, Target 15/16: 29 Hours Perf. Corridor: Red >33 Yellow 30 - 33 Green <30

Q3 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-Q3	14.8	**7**
15-Q4	16.0	**7**
16-Q1	13.7	**10**
16-Q2	14.2	**10**
16-Q3	16.5	**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 Alternate Level of Care (ALC) and there are a number of initiatives underway.

In October 2015, an 18 month patient flow action plan was approved by the SE LHIN Executive Forum. Three areas of focus are the inflow & Emergency Department diversion; intrahospital patient flow; and outflow including patient discharge planning. There are 12 to 20 projects/activities associated with each area of focus. The work is aligned to the LHIN wide action plan to drive change in patient flow across the region.

We are re-educating staff about the Home First philosophy to promote the expectation that patients will be discharged back home to make decisions regarding long term care rather than waiting in the hospital.
November Learning Rounds featured a presentation on Health Links and how we play a role in this regional initiative and December Learning Rounds focused again on Home First.

An ALC escalation guideline is near completion. This procedure will require senior leadership approval prior to designating a patient ALC for long term care to ensure all other discharge destinations are not viable options.

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 our patients are occupying an acute care hospital bed once the acute phase of his/her treatment is finished. The total number of ALC days is influenced by both the number of ALC patients and their ALC-specific lengths of stay.

The Q3 result of 16.5% indicates that, on average, there were 70 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. Q4 actions to address will include enhances LHIN engagement to create processes to better understand system challenges.

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%

Kingston General Hospital

Q3 FY2016 Strategy Performance Indicators Report

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

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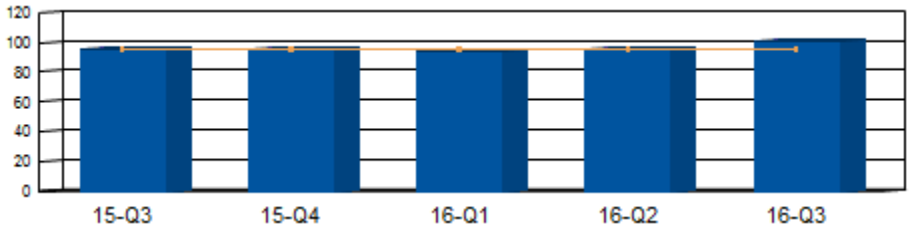
Indicator: Overall Medical/surgical Occupancy Rate (Midnight Census)



	Actual	Target
15-Q3	96	**95**
15-Q4	96	**95**
16-Q1	94	**95**
16-Q2	96	**95**
16-Q3	101	**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 force continues to identify opportunities for improvement with patient access to care in the face of increasing ALC-designated patients. 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 Q3 overall medical/surgical occupancy rate increased to 101% this quarter. The Q3 result is predictable as seasonal patterns see unscheduled and increasing numbers of patient being admitted. Medicine occupancy rose to 105% and surgical occupancy rose to 98%. Overall length of stay rates continue to be positive. The impact of increasing numbers of patients means that additional inpatient capacity is opened to help manage delays for patients. All inpatient units across the hospital saw sustained or higher occupancy levels. This has been influenced by regional capacity challenges resulting in an inability to repatriate patients in a timely manner.

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, it is however unlikely that we will achieve this target this fiscal year.

Definition: DATA: Decision Support COMMENTS: Cynthia Phillips 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.

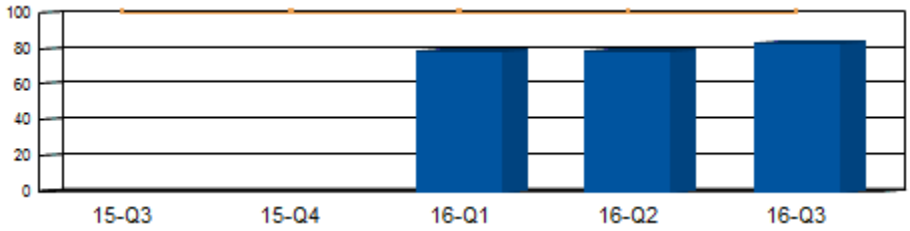
Target: Target 14/15: 95% Perf. Corridors: Red >=100% Yellow 96%-99% Green =95%,Target 15/16: 95% Perf. Corridors: Red >=100% Yellow 96%-99% Green =95%

Q3 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-Q3		**100**
15-Q4		**100**
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	83	**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 two 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 48 of the 58 (83%) surgical categories meet their target threshold. The breakdown of the 10 that did not is as follows: 1 Gyn Surg, 2 Neuro Surg, 1 Oral Surg, 2 Ortho Surg, 2 Plastic Surg, 1 Urol Surg. and 1 Ped Dental Surg. Of the 2 DI categories MRI priority 4 cases did not meet the 80% target (64%), the CT priority 4 cases did. Of the 3 cardiac categories, all 3 meet the 80% target. Therefore, overall 52 of 63 (83%) 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. 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 categories 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.

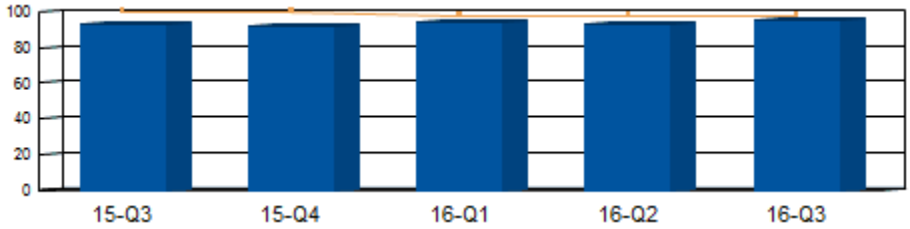
Target: Target 2014/15: 100% Perf. Corridors: Red <80% Yellow 80% - 90% Green 90%+,Target 2015/16: 90% days Perf. Corridors: Red <80% Yellow 80% - 90% Green 90%+

Q3 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-Q3	93	**100**
15-Q4	92	**100**
16-Q1	94	**98**
16-Q2	93	**98**
16-Q3	95	**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 October, November and December a total of 7628 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those total audits 7237 were in compliance or 95%. The individual standards are being reported at a corporate compliance rate of at least 93%. (Badges 93%, whiteboards 94%, Communication 98%, hourly rounding 96%) For those areas not meeting the goal directors and managers look to find ways of supporting staff and physicians to increase their compliance.
The # of feedback forums completed stands at 7.
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 76% for the 3rd quarter with Staff having a 96% compliance rate; together they generate 93% 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. As the performance corridor is green for anything above 80% we will remain green.

Q3 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.

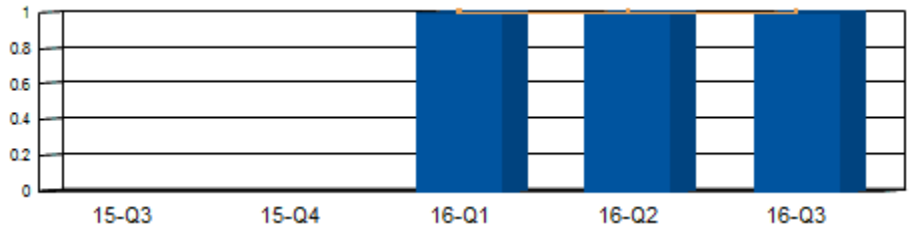
Target: Target 14/15: 100% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%,Target 15/16: 98% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%

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

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

Stage 4.1 (Pre-Tender Submission) documents were submitted to the Ministry of Health and Long-Term Care (MOHLTC) in the third quarter. We anticipate receiving approval from the MOHLTC to move forward to issue for tender before the fourth quarter has ended. Once a contractor is selected we will submit Stage 4.2 (Final Estimate of Cost Submission) documents to the MOHLTC for final approval to commence construction with the contractor awarded the project. We anticipate going to construction in the second quarter of F2017 with completion/occupancy completed by fourth quarter of F2017.

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

Q3 FY2016 Strategy Performance Indicators Report

Cultivate patient oriented research

Externally funded research at KGH has increased by 50%

The new W.J. Henderson Centre for Patient Oriented Research will be a significant milestone in demonstrating KGHRI's mission of "discovery today, treatment tomorrow". Dr. Amer Johri's research into cardiovascular imaging is an example of the type of research that will be occurring in the new Centre once built in early 2017. His role 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.

Just as 3D technologies are revolutionizing the worlds of entertainment and printing, the power of 3D imaging is transforming health care. For Dr. Johri, assistant professor of echocardiography at Queen's University and a clinician scientist at KGHRI, the rapid growth of 3D ultrasound imaging of the heart and vascular system opens up promising opportunities for advancing both patient care and doctors' clinical skills.

Dr. Johri has made progress on both fronts. Returning to Queen's in 2010 after completing an advanced fellowship in echocardiography at Harvard University Medical School, he created the Cardiovascular Imaging Network at Queen's (CINQ) as a way to build existing, but disparate, pockets of strength in heart research into an investigative hub focused on imaging.

"I saw it as a home for people interested in cardiovascular imaging, as a way to share resources and expertise," says Dr. Johri, a member of KGHRI who also holds the distinction of Fellow of the American Society of Echocardiography for his contributions to the field of ultrasound. "I knew what resources were available, what would work, and I had good relationships with the cardiologists. It was fun to start something from scratch."

One of the centre's significant areas of research is in the use of 3D ultrasound imaging of the carotid arteries, the major blood vessels in the neck, to detect heart disease. "Quantifying the buildup of the fatty deposits called plaque in the neck vessels can be a predictor of blockages elsewhere," he explains. It's a relatively new area of research in which his group has already made an impact, he says. "Our results indicate that complete carotid ultrasound may serve as a simple, inexpensive, and low-risk test to rule out significant atherosclerotic cardiovascular disease."

CINQ is also looking at measuring heart function through changes in the heart muscle not visible to the naked eye, using an advanced imaging technology known as "strain" or "speckle-tracking."

A third study, conducted in collaboration with researchers at the Robarts Research Institute in London, Ontario, will incorporate 3D ultrasound into examining the effects of carnitine, a naturally occurring compound found in the body as well as in some foods, on patients with metabolic syndrome, the multiple conditions associated with heart disease that include obesity, diabetes, high blood pressure and high cholesterol. The study was awarded a Heart and Stroke Foundation of Canada grant and also received support from the Department of Medicine and the Southeastern Ontario Academic Medical Organization (SEAMO).

A fourth area of research for Dr. Johri's lab is the study of the use of point of care ultrasound and development of training methodologies. Advancements in ultrasound are also making a difference in how doctors examine their patients. In collaboration with Dr. Anthony Sanfilippo (associate dean, undergraduate medical education) the CINQ lab in 2010 began training medical students to use portable hand-held ultrasound during their physical exams of cardiac patients, making Queen's School of Medicine one of the first to apply the emerging technology to clinical practice.

"All of the above are made possible because of KGH's commitment to patient-oriented research," says Dr. Johri. "It's why I love the idea of the KGHRI, because it supports the idea that research is important."

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 anticipating 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 fourth 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.

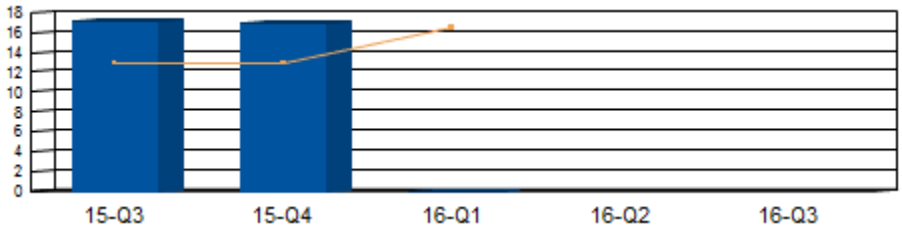
Target: Target 15/16: As per stated project milestones Perf. Corridor: Red 0 = No Yellow N/A Green 1=Yes

Q3 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-Q3	17.18	**12.9**
15-Q4	16.89	**12.9**
16-Q1		**16.47**
16-Q2		
16-Q3		

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 above target, however it is worth noting that this performance dates back to Q4 of last fiscal year. The current target for F 15/16 is higher than previous fiscal and is based on an expected rate. The Q4 KGH rate of 16.89 is below the expected rate of 17.14 which would make our performance green. 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.

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 most recent data for Q4 F 14/15 indicates that we did not make the target of 12.9. However, if the expected rate for Q4 F14/15 were to be compared we would be below target or 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.

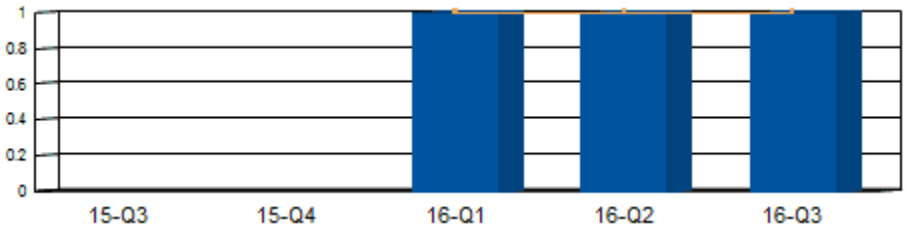
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected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

Q3 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-Q3		
15-Q4		
16-Q1	1	**1**
16-Q2	1	**1**
16-Q3	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 have completed our current state analysis and continue to conduct environmental analysis and stakeholder engagement through our internal forums and our work with the Health Care Tomorrow Hospital Services project. In Q3, we:

- Kicked off the process of developing our 2016-17 Integrated Annual Corporate Plan and Quality Improvement Plan
- Obtained endorsement from our board and Strategy Advisory Council to extend our existing strategy for two years while we continue to work with our health system partners on the Health Care Tomorrow Hospital Services initiative to build a sustainable system of integrated hospital care
- Refreshed the strategic directions within our Strategy for achieving Outstanding Care, Always as a basis for engaging the organization to help set new KGH 2018 outcomes and improvement priorities that advance our clinical, academic and operational 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 are performing well against this target based on our plan to extend our existing strategy for two years while we continue to work with our health system partners on the Health Care Tomorrow Hospital Services initiative to build a sustainable system of integrated hospital care.

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

We are on track to deliver a refreshed strategy for achieving Outstanding Care, Always, as well as a 2016-17 Integrated Annual Corporate Plan by March 21, 2016. In Q4, we will:

- Finalize our refreshed strategic directions
- Engage the KGH community in a conversation about how we will bring the strategic directions to life (Team Talks, Strategy Advisory Council, KGH committees & councils, board, etc.)
- Establish specific targets, indicators and corridors of performance for 2016-17
- Deliver a 2016-17 Integrated Annual Corporate Plan, Quality Improvement Plan in the context of our refreshed Strategy for achieving Outstanding Care, Always

Definition: DATA: Theresa MacBeth COMMENTS: Theresa MacBeth EVP: Silvie Crawford REPORT: STRATEGY REPORT

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

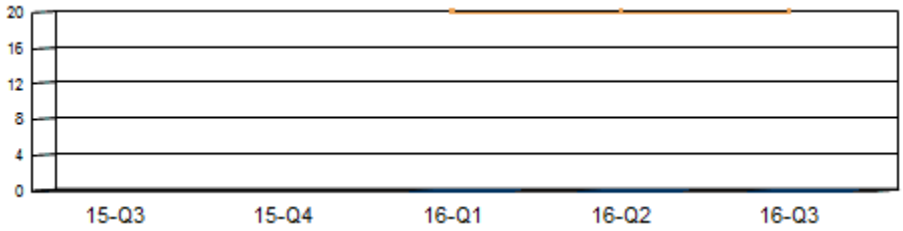
Kingston General Hospital

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

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

Leadership Development continued as an area of focus including participants in the OHA conference, completion of the Leading a Mentally Healthy Workplace Certificate program, and the roll out of LIFT which includes frontline and emerging leaders training. The Hospital Liaison Committee for medical students continued and Library Services in partnership with Providence Care was launched. The engagement surveys were a major focus in Q3 with participation rates at or above the rates 2 years ago. A continuous learning policy was developed for oversight and management of available opportunities.

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 plus the volunteer survey took place in November. An infographic was developed to focus on improvements to the 4 areas of corporate focus including education, training and learning. Results are expected in Q4 which will be shared with teams and on a corporate level. A review of the items of focus will occur to assess if these demonstrated improvement.

Definition: DATA: M. Mulima COMMENTS: M. Mulima EVP: Sandra Carlton 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

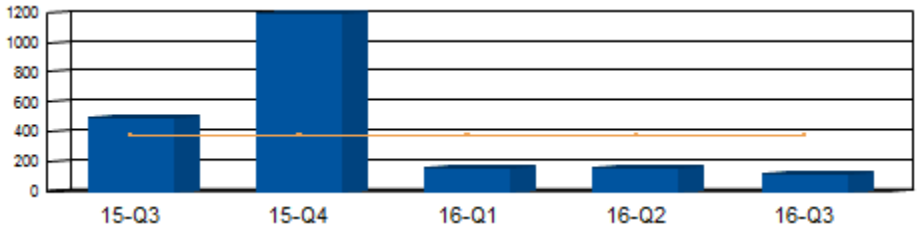
Kingston General Hospital

Q3 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-Q3	495	**375**
15-Q4	1,198	**375**
16-Q1	158	**375**
16-Q2	159	**375**
16-Q3	116	**375**

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

There were 433 completed performance plans at the end of the quarter. The gap was in particular for our unionized staff. Information and training sessions took place for leaders and staff. Individual leader communication and data was shared.

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. This has also been included as a shared target for all leaders in performance agreements.

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 further highlight the target and completion rate will continue. For challenging areas for staff to meet with their leader, group and alternative meetings will be undertaken. Given the link to engagement it will also form part of the engagement discussions in Q4. The completion rate from last year was over the target at 2084 brings the overall 2 year total to date at 2517, short of the 3000.

Definition: DATA: Micki Mulima COMMENTS: Micki Mulima EVP: Sandra Carlton 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

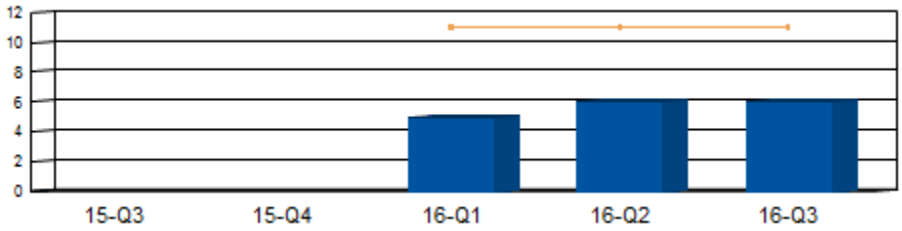
Kingston General Hospital

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

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

In all, there were 20 reported MSIs that occurred due to patient handling in Q3 with 45% of the incidents occurring on one unit (Connell 10) . Six (6) of the 21 injuries resulted in WSIB claims, with 4 of these being health care claims and 2 being lost time injury (LTI) claims. Five (5) of the 6 claims resulted from activities related specifically to patient transfers. Each LTI resulted in a day of lost time.

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

Activities undertaken in Q3 to support injury reduction included: the implementation of 4 transfer poles on Connell 10 as a pilot project to promote safer patient transfers, exploring the benefit of a fitted sheet that works in conjunction with the existing Breeze sheet to facilitate patient repositioning in bed with less risk to the health care worker, conducted a comprehensive audit of clinical units with high incidence of staff musculoskeletal injuries assoc. with patient handling which included an audit of staff use of current processes and tools to support safe patient mobilization, and conducted staff training on a new sit to stand lift on Davies 4 to facilitate early and safe patient mobilization.

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

Yes. In Q4 findings of the risk assessment will be taken to the Falls Committee to explore actions to be taken to support safe patient mobilization with fewer falls, and reduction in staff MSIs associated with patient handling activities.

Definition: DATA: J. Noonan COMMENTS: J. Noonan EVP: Sandra Carlton 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.)

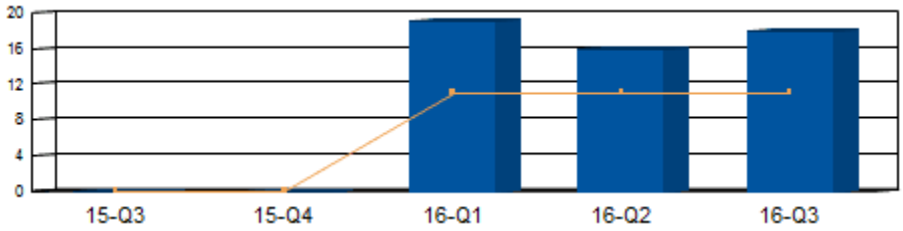
Kingston General Hospital

Q3 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-Q3	0	**0**
15-Q4	0	**0**
16-Q1	19	**11**
16-Q2	16	**11**
16-Q3	18	**11**

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

In total, 34 incidents of violence were reported with the highest incidence in the Medicine program (n=10), Mental Health program (n=10), ED (5) and SPA program (5). Of the 34 incidents, 18 staff reported they sustained injuries. Of the 18 reported injuries, all were either no treatment/self treatment/first aid, with the exception of 1 which resulted in a health care claim when the worker attended the ED to be assessed. No lost time injuries claims occurred related to violence

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 review of the 34 incidents, 21 patients (62%) had an active Behavioural Crisis Alert (BCA) in place prior to the incident. In random auditing of the BCA program compliance across the hospital, only 32% of patients with an active BCA had any notation of the kardex to communicate the specific risk reduction strategies to be taken.

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

Risk Reduction Plans (care plans) for aggressive/violent behaviour are currently in place in Burr 4 and Kidd 7; Kidd 4 is initiating a trial of the risk reduction plan in Feb/16. After the final trial we will evaluate the form for possible re-application throughout the hospital. E-learning with a focus on risk strategies to prevent/manage aggression is currently in development with a target release date of March/April 2016. Non-Violent Crisis Intervention (NCVI) initial and refresher training continues in Q4 for areas at highest risk of violence (ED, Mental Health, Kidd 7, Connell 3, 9, 10). KGH Workplace Violence Taskforce in place and continues to pursue items on its action plan.

Definition: DATA: J. Noonan COMMENTS: J. Noonan EVP: Sandra Carlton 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.

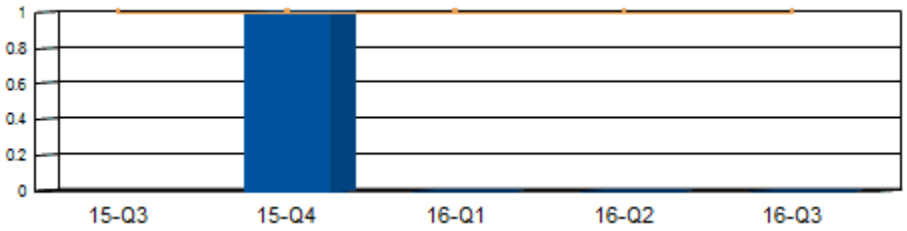
Target: Target 2015/16: 44(11/qtr) Perf. Corridor: Red >49(>13/qtr.), Yellow 45-49 (12-13/qtr.), Green <=44 (<=11/qtr.)

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

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

On 18 November, the Ministry posed 69 questions in regards to our Stage 1 submission. Working with our internal stakeholders and consultants Agnew Peckham and HDR, we formally responded on 20 January 2016. On 22 January we provided a tour of the Phase 2 priority areas to Peter Kaftarian, Director, Capital Branch, MOHLTC. Plans have also been made to tour the Deputy Minister, Bob Bell through our site in late March. Unfortunately at this point in time the Ministry of Health and Long Term Care has not provided any further details to the health system as to when they will make any capital announcements for hospitals.

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

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

Definition: DATA: 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)

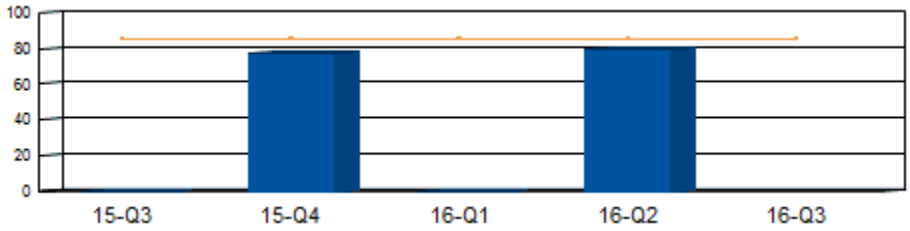
Kingston General Hospital

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

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

Management reorganization plan has been implemented and completed giving additional management resources to oversee the services more effectively including conducting internal audits of cleaning performance. Duty list assignments for Environmental Services has been completely reorganized to improve efficiency and accountability as well as balancing the workload. Additional resources were added to the Emergency Department to rectify a consistent deficiency in this area. A dedicated floor care team was created to address flooring issues throughout the hospital. These changes were implemented on January 25th. Internal audits will be conducted daily to identify challenges, training opportunities and to monitor compliance to cleaning standards. Any audits scoring below 85% will be immediately rectified. A monthly surprise "Mini Audit" (60-80 audits in a single day mimicking the official Westech Audit) will be conducted to take a temperature check of current state.

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

Last official Westech Audit was conducted in July of 2015 resulting in a score of 80.47%. Next Westech Audit is being scheduled for about April 2016. An internal self-audit (208 Audits) was conducted in late November resulting in a score of 75.23%. A monthly surprise "Mini Audit" (60-80 audits in a single day mimicking the official Westech Audit) will be conducted to take a temperature check of current state. Next mini audit to be conducted in late February

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 anticipate that these changes will have a significant impact on our audit scores

Definition: DATA: Bryan Harvey COMMENTS: Bryan Harvey EVP: Brenda Carter REPORT: STRATEGY REPORT

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

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

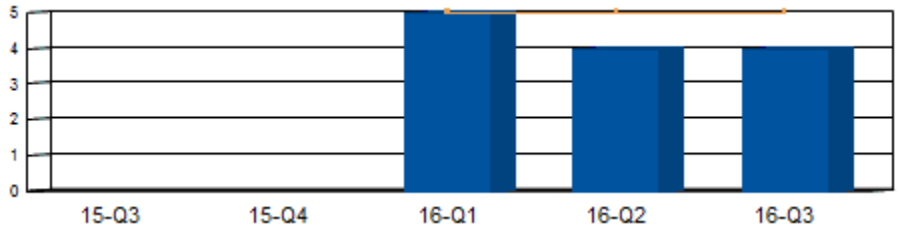
Kingston General Hospital

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

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

1. As previously reported, the Hospital Information System (HIS) clinical and technical requirements were finalized and the Request for Proposal (RFP) was ready for release at the end of last fiscal year. The final decision regarding the release of the HIS RFP is subject to the Healthcare Tomorrow timelines and the provincial HIS review. Work is underway to hire an external consultant to complete the costing analysis for the technology.

2. The South East LHIN cNEO Implementation project is on schedule with 3 of 7 hospitals ready for stage 2 data contribution at the end of Q3 (KGH, HDH & Brockville). The remaining hospitals will follow in Q4. The change management phase was initiated and the clinical stakeholders at each hospital were provided with a demonstration of the clinical viewer as well as implementation timelines.

3. The Automated Chemistry Track project has completed validation and the equipment had a successful go live in November. The auto-validation phase for the instruments has been scheduled for February 1, 2016. The construction for the project is on schedule and the lab is ready for the chemistry track which will arrive in Kingston on January 16th. The track is expected to be installed and ready by the end of May 2016.

4. The Internet phase of the Web Redevelopment project had a successful go live in December. The post implementation review is currently underway which includes lessons learned and closing documentation. The planning phase for the Intranet stage of the project is scheduled to begin in mid-January.

5. The Project Management Office (PMO) is performing a review of the Staff Scheduling and Time Capture project to evaluate governance, change management and business objectives. This review will help inform and drive a decision on options to course correct in order to address the challenges experienced while continuing to deliver on the strategy.

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 is only one concern with the project portfolio's overall performance. After the initial on-boarding phases for the Staff Scheduling and Time Capture project, staff and management feedback have led to a full project review that may change the projects scope thus impacting timelines and costs for completion. A new project manager has been assigned to the project and a revised plan will be in place during Q4.

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?

The projects are on track to meet their planned targets by the end of the fiscal year with the exception of the Staff Scheduling and Time Capture (SSTC) project. SSTC will have a revised plan in Q4 and a schedule variance is likely to occur based on the information at the time of this report.

NOTE: 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.

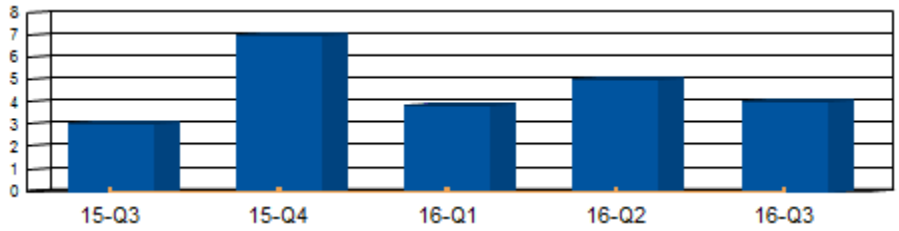
Target: Target 2015/16: As per implementation schedule Perf. Corridor: 1=YES, 0 = NO

Q3 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-Q3	2.99	**0**
15-Q4	7.03	**0**
16-Q1	3.86	**0**
16-Q2	5.04	**0**
16-Q3	4.02	**0**

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

The hospital continued to provide financial analysis monthly to those with budget responsibility throughout the last quarter. Discussions were also undertaken at the end of the second quarter relative to projecting the year-end financial position. These process informed decision making.

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

The hospital is operating in excess of a balanced budget position through three quarters of the fiscal year, thus the favourable total margin result.

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

The positive variance year-to-date will offset the HBAM funding reduction for the last quarter of fiscal 2016. Senior leadership is projecting 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 the operational activity throughout the next three months occurs within the budget fiscal constraint. High-level summary results by category will 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

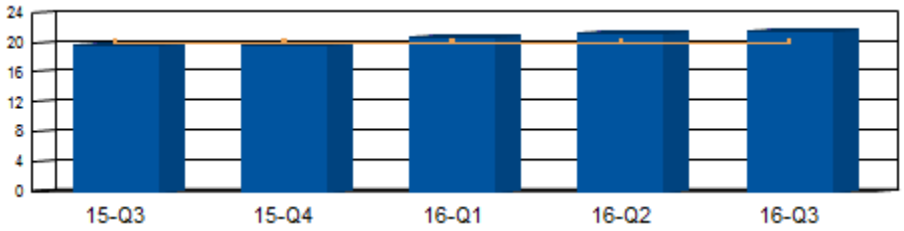
Kingston General Hospital

Q3 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-Q3	19.7	**20**
15-Q4	19.7	**20**
16-Q1	20.7	**20**
16-Q2	21.3	**20**
16-Q3	21.4	**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 $21.4 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?

Based on a projected balanced operating budget for the fiscal year, hospital leadership endorsed spending for the entire capital budget capacity during the third quarter of the fiscal year.

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

Q3 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