fiscal 2015-2016 **Q4**

4th quarter ended March 31, 2016

KGH this quarter

Strategy Performance Report

Kingston General Hospital

Outstanding care, always

KGH Strategy Performance Report Fiscal 2016 Q4

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 Q4

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 Q4

Kingston General Hospital

Q4 FY2016 Strategy Performance Indicators Report

Strategic Direction	2016 Outcome	Indicator	15-Q4	16-Q1	16-Q2	16-Q3	16-Q4	
Transform the patient experience through a relentless focus on quality, safety and service	Patients are engaged in all aspects of our quality, safety, and service improvement initiatives	Overall, How Would You Rate the Care You Received at the Hospital? (QIP)	G	G	Y	Y	Y	↓
	All preventable harm to patients is eliminated	C-Difficile (Reported Quarterly) (QIP)	R	R	R	G	R	↑
		Hand Hygiene Compliance - (QIP)	R	R	Y	Y	Y	↓
		Hospital Standardized Mortality Ratio (HSMR) (QIP)	R	N/A	N/A	N/A	N/A	↓
		Medication Reconciliation at Admission (QIP)	R	R	R	Y	Y	↑
		The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)	R	R	G	R	G	↑
		All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)	G	G	G	G	G	↑
		Twenty-five percent fewer patients experience skin ulcers on the 3 units (across 3 programs - medicine/surgery/critical care (K6, C10, K2 ICU)) - (QIP)	N/A	Y	Y	Y	R	↓
		Number of Incidents Associated with Morphine or Hydromorphone	G	G	G	Y	Y	↓
		Number of Specimen Collection and Labelling Errors	R	R	Y	G	R	↓
	All preventable delays in the patient journey to, within, and from KGH are eliminated	90th Percentile ED Wait Time - All Admitted Patients (hrs.) - (QIP)	R	G	G	Y	R	↓
		Percent ALC Days (QIP)	R	R	R	R	R	↓
		Overall Medical/surgical Occupancy Rate (Midnight Census)	Y	G	Y	R	R	↓
		Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target	N/A	R	R	Y	R	↓

Strategic Direction	2016 Outcome	Indicator	15-Q4	16-Q1	16-Q2	16-Q3	16-Q4	
	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	G	G	G	G	↑
Increase our focus on complex-acute and specialty care	KGH services are well aligned and integrated with the broader health care system	30 Day Readmission Rate Outperforms its Expected MOH rate (QIP)	Y	G	N/A	N/A	N/A	↓
		KGH Strategy Development Process Deliverables are met	N/A	G	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	G	G	G	G	↑
		Number of Staff with Performance Reviews and Agreements on File	G	R	R	R	G	↑
	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	G	G	G	G	↑
		The incidents of workplace violence injuries are reduced from 50 to 44 per year	N/A	R	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	Y	N/A	Y	N/A	G	↑
	Rapid transmission of information improves care and operational efficiency	Number of Strategic Technology Projects Implemented on Schedule	N/A	G	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 ↓

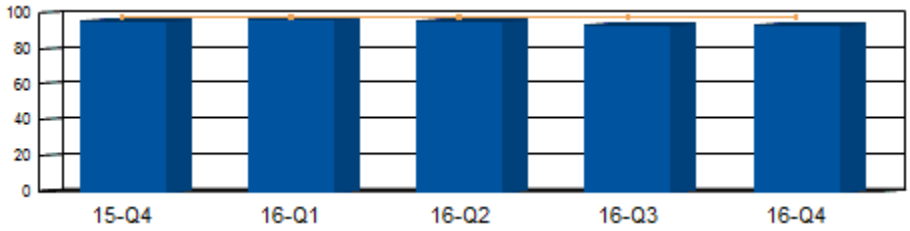
	Strategy					QIP					Supporting				
	F16					F16					F16				
	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #	Q1 %	Q2 %	Q3 %	Q4 %	Q4 #
R	37%	26%	22%	33%	9	50%	33%	25%	42%	5	39%	36%	28%	37%	28
G Y	63%	74%	78%	67%	18	50%	67%	75%	58%	7	61%	64%	72%	63%	47
N/A	0%	0%	0%	0%	0	0%	0%	0%	0%	0	0%	0%	0%	0%	0
					27					12					75

Q4 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-Q4	95	**97**
16-Q1	97	**97**
16-Q2	95	**97**
16-Q3	93	**97**
16-Q4	93	**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

Q4 FY2016 Strategy Performance Indicators Report

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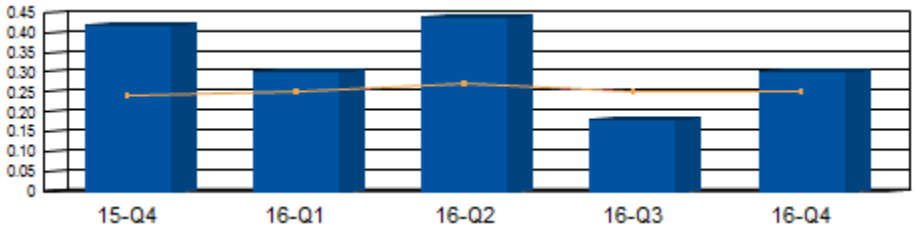
Indicator: C-Difficile (Reported Quarterly) (QIP)



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

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

The tactic work plan for 2015-2016 was to continue to build on 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 Inpatient Program 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:

There were 12 cases this quarter; January there were 6 cases; February there were 3 cases; and again in March there were 3 cases. Overall for 2015 - 2016, we had 46 cases of CDI. In comparison in 2014 - 2015 we had 50 cases; in 2013 - 2014 we had 77 cases and in 2012 - 2013 we had 88 cases.

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

Although our target was not met, overall we had 4 fewer patients develop CDI this year compared to last year. The downward trend has been sustained for > 4 years. Plans for 2016 - 2017 include continued collaboration between In-patient Programs and IPAC Service to ensure the prompt identification and initiation of Contact Precautions on the units; reporting of suspect cases to IPAC. IPAC continues to promote the CDI Order Set and appropriate discontinuation of precautions. IPAC will continue to notify ES of inpatient rooms and bathrooms requiring twice daily cleaning. A sporicidal cleaner will continue to be used by ES for discharge cleaning on identified units.

Definition: DATA: Darlene Campbell COMMENTS: Dr.Gerald Evans EVP: David Zelt REPORT: STRATEGY REPORT

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

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

Kingston General Hospital

Q4 FY2016 Strategy Performance Indicators Report

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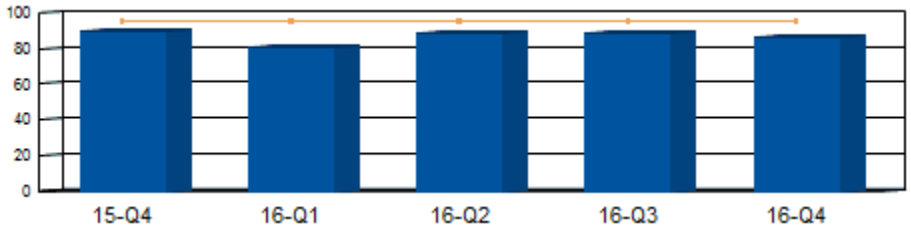
All preventable harm to patients is eliminated

Indicator: Hand Hygiene Compliance - (QIP)



	Actual	Target
15-Q4	89.4	**95**
16-Q1	81.0	**95**
16-Q2	88.0	**95**
16-Q3	88.0	**95**
16-Q4	86.0	**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 auditors, working directly with Programs, attending staff meetings to clarify Patient Environment vs. Hospital Environment. The supporting Resource Tool were developed and posted on each in-patient unit, Renal Unit and Cancer Clinic. Hand Hygiene LMS module was developed and roll-out across the organization has begun this quarter. It will be mandatory of 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:

Q4 the average was 86% for Moment 1 a decrease from Q3 and Q2 when the average was 88%. Total opportunities observed in Q4 also decreased from Q3 6,818 opportunities to 6,126.

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

The target was not met. Further roll out of the new LMS module and "Just in Time" intervention education by the auditors will need to continue in 2016 - 2017. The Hand Hygiene Working Group (HHWG) will continue to research and identify new initiatives to improve compliance rates and optimize patient's safety by reducing opportunities for transmission of organisms via the healthcare workers hands.

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%

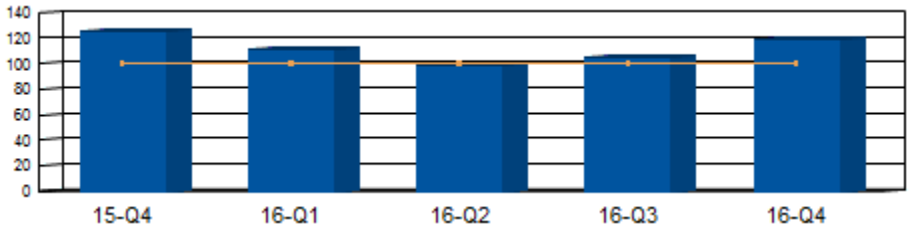
Kingston General Hospital

Q4 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-Q4	126	**100**
16-Q1	112	**100**
16-Q2	99	**100**
16-Q3	105	**100**
16-Q4	119	**100**

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

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

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

CIHI has changed is methodology in assessing the HSMR and no longer calculates confidence limits and hence the significance of the quarterly HSMR cannot be determined. Hence the current methodology to track the HSMR can no longer be translated into our metric evaluation criteria. Nevertheless, the quarterly tracking suggests concern. Mortality reviews have thus far shown no concern. Working with Patient Records and Decision Support, a deeper dive on the quality of documentation is underway with the concern that co-morbidities that increase risk of mortality are not documented adequately to inform data extraction.

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

Given the change in methodology at CIHI, the current metric cannot be properly graded. Data is being further analyzed to review documentation od comorbidities.

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.

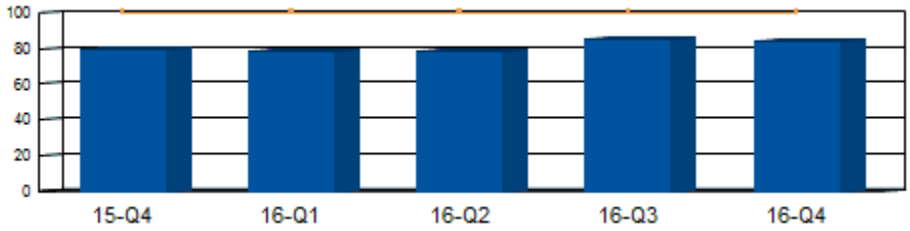
Target: Baseline 08/09: 111 , Target 09/10: 100, Target 10/11: 100, Target 11/12: 106. Target 12/13: 100, Target 13/14: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant, Target 14/15: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant, Target 15/16: 100 Perf. Corridor: Red Statistically Significant Results Yellow N/A Green Statistically not Significant

Q4 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: Medication Reconciliation at Admission (QIP)



	Actual	Target
15-Q4	79	**100**
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	85	**100**
16-Q4	84	**100**

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

Fiscal 2015-16 Integrated Annual Corporate Plan Tactics are achieved:
1. Ensure physician engagement in the medication reconciliation process
   MAC approved mandatory annual education for physicians

2. Implement a prescriber education program for medication reconciliation
   LMS module for physicians completed by Pharmacy and Leadership and Learning.

3. The medication reconciliation process is embedded as part of all admission order sets.
   Revised template approved by the Order Set Committee.
Medication Reconciliation at Care Transitions (Acute Care) policy drafted.

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 increase in the percentage of patients who receive medication reconciliation at the time of admission to the Hospital that was achieved in F16 Q3 continues in F16 Q4 at 84%.

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

Target of 90% compliance by F16 Q4 not achieved.
Enforcement of requirement for medication reconciliation on admission for all patients by policy will support the Hospital achieve target in F17.
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 April 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%

Q4 FY2016 Strategy Performance Indicators Report

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

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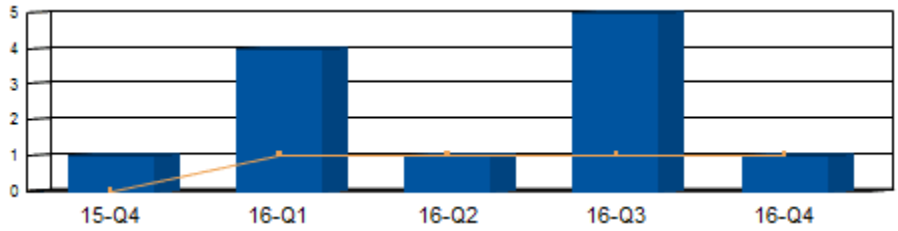
Indicator: The Number of Patient Falls in Level 3 and Level 4 categories - (QIP)



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

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

This quarter an assessment of the program was completed by looking at the completion of risk assessment which remains at about 90% across the organization. The falling star program is in place and there is good reporting of falls in our reporting system. The safe reports have been analyzed with a consistent theme of falls occurring in bathrooms or surrounding toileting. The falls working group is engaged at the present time with 2 patient experience advisors to assist us to understand falls from the patient's perspective. We are also looking at patient falls and any correlation with injuries to staff as a result of falls.

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

This quarter we had one fall that resulted in a level 3 report in the inpatient population that did result in significant injury. A complete review was completed regarding this event and strategies put in place to mitigate future falls.

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

Looking at workflow on the nursing units with special emphasis on patient needs regarding toileting will be of primary concern for the upcoming year. Occupation Health has done significant work looking at equipment and training of staff that will impact this indicator. There will be continued auditing of application of our falling star program and its affect at preventing injury from falls with an emphasis on reducing preventable harm due to fall. We are actively reaching out to other organizations to learn strategies that could improve our program.

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

Q4 FY2016 Strategy Performance Indicators Report

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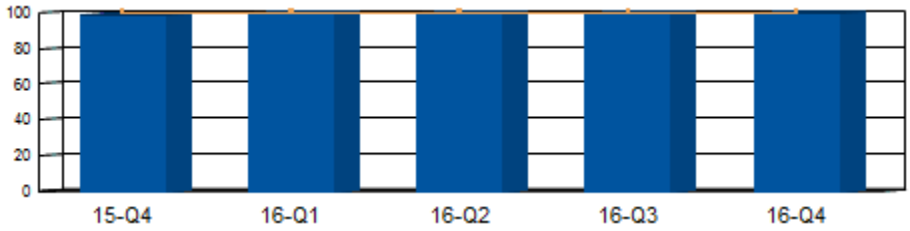
Indicator: All Three Phases of the Surgical Safety Checklist are Performed (Briefing, Time Out, and Debriefing) - (QIP)



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

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

The monthly review of the Surgical Safety Checklist metrics by the Program council and at OR staff meetings continue to assist in the sustainability of meeting this target.

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

For the 4th quarter this indicator continues to meet the green target corridor. There were 2,183 surgical cases completed in this quarter in the main operating rooms. The compliance for the Surgical Safety checklist 3 phases were the following: Briefing- 99.9%, Timeout-99.8%, and Debrief- 99.9%.

The Connell 5 Labour & Delivery operating rooms completed 138 caesarean sections this quarter. The compliance for this area for the 3 phases of the checklist was the following: Brief:=98.6%, Timeout=97.8% and Debrief=96.4%. Education review for staff on the importance of completion is being implemented.

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

Overall target is met.

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.

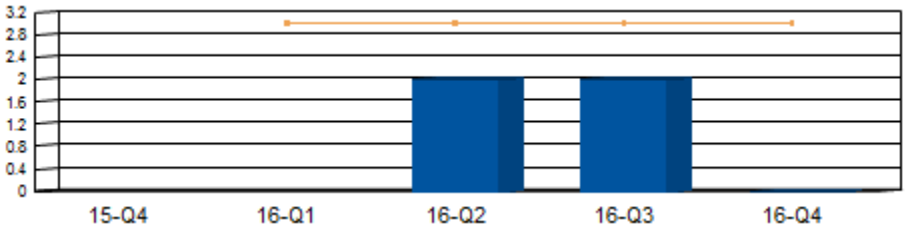
Target: Target 2012/13: 100% Target 2013/14: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%,Target 2014/15: 100% Perf. Corridor: Red <95% Yellow 95%-97% Green >97%, Target 15/16: 100% Red <85% Yellow 85%-94% Green: >95%

Q4 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-Q4		
16-Q1		**3**
16-Q2	2	**3**
16-Q3	2	**3**
16-Q4	0	**3**

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

This quarter, a second Learning module for all registered nursing staff (completion rate of 43% at end of quarter) as well as a learning module for patient care assistants (completion rate of 42% at end of quarter) was launched. Weekly in-services on the targeted units continued throughout the quarter. The skin champions were brought back together with education on how to do pressure ulcer prevalence study and staging of pressure ulcer education completed. The heel ulcer prevention working group conducted a trial of heel offloading boots which is 50% completed on the orthopedic unit. A patient and family pressure ulcer prevention education pamphlet was created to assist patients and family with understanding of how they can participate in their care and prevent pressure ulcers was created and should be ready to launch in May. As well, KGH participated in our first ever international pressure ulcer prevalence study. This study is conducted by each facility doing pressure ulcer prevalence on the same day of the year. It is international, but 70% of the participants were from Ontario with last year's study. This will not only give us information about our own organization, but will allow us to understand what the pressure ulcer prevalence is in other organizations. We should be receiving final results in May.

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

This quarter we did not meet target in any of the targeted areas making our performance Red for this quarter. Our target was to have a 25% reduction in the prevalence of pressure ulcers as compared to the Feb 2014 data. Two areas achieved targets less than the prevalence we had been measuring against but we did not succeed in reducing the incidence by 25% on any of the units. K2ICU had a prevalence of 47% in Feb/14 and Q4/16 prevalence was 40%. K6 prevalence Feb14 was 27% with Q4/16 prevalence of 24% and C10 prevalence Feb 14 was 35% with Q4/16 of 36%. The increase in prevalence was increased the last two months of the quarter in all three areas. This continued variability in the prevalence rates provides us with evidence of the continued need to reinforce consistent sustainable practices.

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 our target this year. We have ongoing strategies that will assist us as we move into the new fiscal year. K2ICU is implementing a "turn team" strategy that will ensure all patients are turned on a regular q2H basis. The ER is doing training with the ER nurses in April to ensure that all admitted patients receive a skin and pressure ulcer risk assessment with in the first 24 hours. A third education module for pressure ulcer prevalence will be launched for the registered nursing staff in May. The skin champions are feeling more comfortable with their knowledge and the ability to support the nurses on their units. They are able to articulate what they are doing on the units to support pressure ulcer prevention and are networking with one another about strategies and projects that will assist. The next pressure ulcer prevalence study will be completed in September of 2016. For the next year we will be continuing to roll out the program across the entire organization, continue to build the skin champions to increase capacity for pressure ulcer prevention at the unit level, and through audit and feedback, we will focus on ensuring every inpatient receives a skin assessment, pressure ulcer risk assessment and plan of care based on the risk assessment within 24 hours of admission.

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

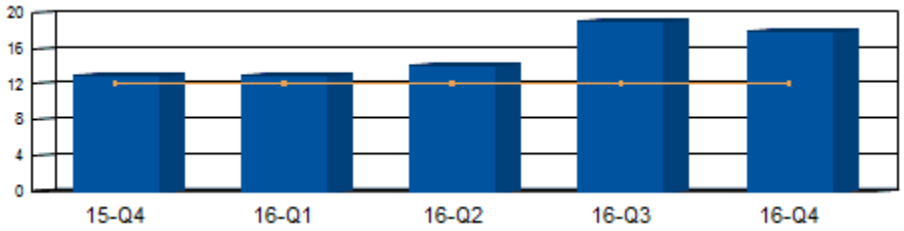
Kingston General Hospital

Q4 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-Q4	13	**12**
16-Q1	13	**12**
16-Q2	14	**12**
16-Q3	19	**12**
16-Q4	18	**12**

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

Fiscal 2015-16 Integrated Annual Corporate Plan Tactics are achieved:
1. Implement mandatory LMS training on morphine and hydromorphone for nursing staff
Tactic implemented in Fall 2015. As of April 2016, 83% of RNs and 78% of RPNs completed the learning module.

2. Implement safeguards for the prescribing, dispensing and administration of high-alert medications
Tactic implemented by April 2016. Hospital is in compliance with Accreditation Canada ROPs for high-alert with the implementation of the Automated Dispensing cabinet's medication access restrictions and alerts. Infusion pump medication alerts will be in place by June 2016.
medications.

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

In Fiscal 2015-16 Quarter 4, there were 18 reported morphine and hydromorphone medication administration incidents.
This is above the improvement priority target of 12 for this quarter.
Three medication administration incidents involved morphine and 15 involved hydromorphone. There were no incidents involving morphine being administered when hydromorphone was ordered or hydromorphone being given when morphine was ordered.
Incorrect medication dose was the most common type of incidents.
Of note, the utilization of hydromorphone has increased by 5% in F16 compared to F15.
A total of 279,563 doses of medications were dispensed by Pharmacy Services during the Fiscal year.
The utilization of morphine has decreased by 12% in F16 compared to F15 with a total volume of 67,413 doses.

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

Target of 12 reported incidents by F16 Q4 not achieved.
Goal to reduce mix up between morphine and hydromorphone (5 to 10 times more potent than morphine) is achieved.

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

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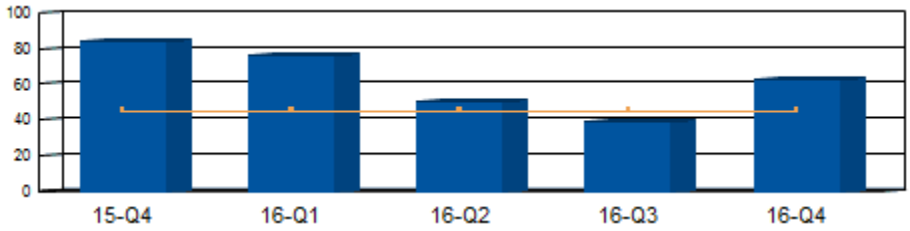
Indicator: Number of Specimen Collection and Labelling Errors



	Actual	Target
15-Q4	84	**45**
16-Q1	76	**45**
16-Q2	50	**45**
16-Q3	39	**45**
16-Q4	63	**45**

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

Overall the specimen collection errors in F16 continued to decrease but in Q4, the indicator moved from GREEN to RED. There are many things that have contributed to the slide in performance such the hospital in "GRIDLOCK" and overcapacity beds in use during the month of January 2016. In the month of January there were 35 unlabelled/mislabelled specimens. The number of specimen collection incidents did drop back down to 18 in February with a further reduction down to 10 incidents in March. Work is underway to continue to meet with clinical stakeholders to promote quality specimen collections and to reinforce the six rights of specimen collection.

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

Specimen collection errors were identified as one of the top three sources of preventable harm to patients at KGH. Laboratory results provide essential data for diagnosis, monitoring and treatment of patients. Delays in laboratory testing can be the result of specimens received in the laboratories that are unlabelled or mislabelled. In either case this means unnecessary delays in the treatment decision or unnecessary testing. It is imperative that the six rights of specimen collection are followed (the right patient, the right requisition/LOE/EDIS, right test, right order of draw, right tube and right labelling).

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

The target for Q4 was not met. Current tactics underway include collaboration with Leadership and Learning creating a learning module for staff to complete and collaboration with Clinical Educators reinforcing knowledge transfer.

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.

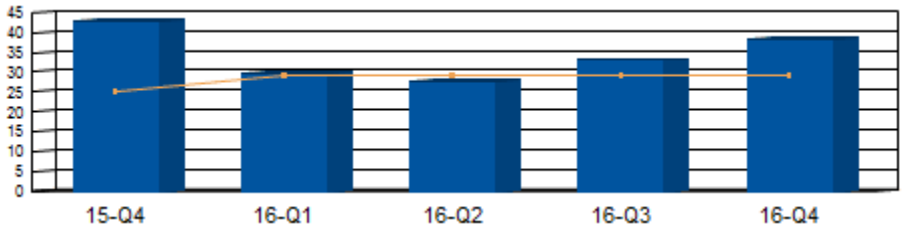
Target: Target 2014/15: 45 Perf. Corridors: Red >75. Yellow 56-75 Green <=55,Target 2015/16: 45/qtr. Perf. Corridors: Red >55/qtr. Yellow 46-55/qtr. Green <=45/qtr.

Q4 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-Q4	42.7	**25**
16-Q1	29.7	**29**
16-Q2	27.6	**29**
16-Q3	33.0	**29**
16-Q4	38.5	**29**

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

GOOG (Get out of Gridlock) huddles continue twice daily to discuss patient flow. Focus this quarter has been on the creation of a new bed map that would consolidate patient cohorts resulting in increased efficiency for care teams. Efficiencies include timelier rounding with optimal participation of all care providers, earlier decisions and arrangements for discharges resulting in more timely bed availability.

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

The Q4 result of 38.5 hours is well over the 29 hour target. Based on Q4 admission volumes of 2676, 241 patients waited more than 38.5 hours in the ED for an inpatient bed. Admission rate from the ED in Q4 was 20% 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 in Q4: LHSC = 37.1, HHSC = 30.9, SMH = 23.6, SHSC = 31.6, TOH = 30.5, TBRHC = 38.6, teaching hospital group 35.6. While ED wait time in this group appears to be up in all of our peer centres, 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 62 for improvement out of 74 hospitals as of the end of December (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?

The year end result is 33.6 hours, 4.6 hours above target

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

This indicator measures the amount of time 9 out of 10 patients (90th percentile) spend in an ED being diagnosed, receiving treatment and waiting for admission to a hospital bed. Most patients spend less time, while 1 out of 10 patients will spend more time. The time being measured is defined as when a patient registers until the time when the patient is admitted to an inpatient hospital bed. For this indicator, 9 out of 10 patients (for all admitted patients at all levels of complexity) will spend no more than 31 hours within the ER from the time they arrive and register to the time they leave the ED.

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

Kingston General Hospital

Q4 FY2016 Strategy Performance Indicators Report

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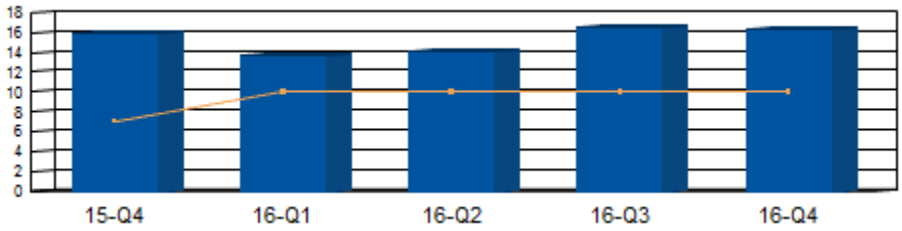
All preventable delays in the patient journey to, within, and from KGH are eliminated

Indicator: Percent ALC Days (QIP)



	Actual	Target
15-Q4	16.0	**7**
16-Q1	13.7	**10**
16-Q2	14.2	**10**
16-Q3	16.5	**10**
16-Q4	16.3	**10**

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

In Q4, there was progress on a number of initiatives in the patient flow action plan. 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 completing the ALC escalation guideline and this will be implemented in Q1. 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.

The SE LHIN granted a priority 1A to KGH for 14 days in February where patients designated ALC for long term care (LTC) received priority placement over community patients in order to improve flow; 8 patients were moved to long term care and 6 new patients were designated ALC-LTC during the 1A time frame. Without this priority, our patient numbers would have increased to a greater degree.

A review of long stay ALC patients was performed to determine challenges to discharge. Results were mobility issues, cognitive impairment, family unable to manage care needs, patients' lives alone, two person transfer or mechanical lift requirement, and financial concerns where patients cannot afford retirement home or additional care expenses. Work will continue to determine how to overcome these barriers to timely discharge from KGH.

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

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 Q4 result of 16.3% indicates that, on average, there were 71 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. Fiscal 16/17 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.

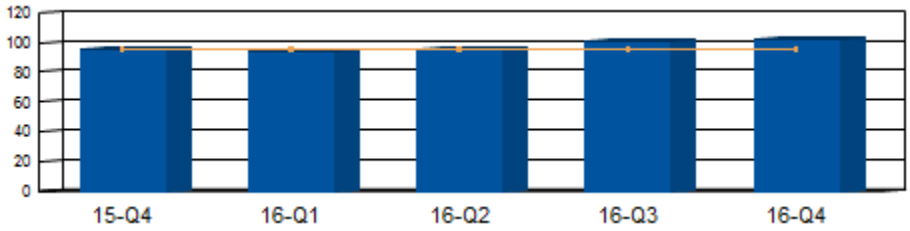
Target: 11/12 Target: 10% 12/13 Target: 10%, Target 13/14: 7% Perf. Corridor: Red >10% Yellow 8%-10% Green <=7%, Target 14/15: 7% Perf. Corridor: Red >9.5% Yellow 8%-9.5% Green <=7%, Target 15/16: 10% Perf. Corridor: Red >13% Yellow >10%-13% Green <=10%

Q4 FY2016 Strategy Performance Indicators Report

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

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

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



	Actual	Target
15-Q4	96	**95**
16-Q1	94	**95**
16-Q2	96	**95**
16-Q3	101	**95**
16-Q4	102	**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. Further, in Q1F2017, work will commence on designing and implementing an updated Bed Map for the majority of the inpatient services in the hospital. We will also focus on strategies related to admission avoidance and Emergency Department diversion.

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

The Q4 overall medical/surgical occupancy rate increased to 102% this quarter. The Q4 result is predictable as seasonal patterns see unscheduled and increasing numbers of patient being admitted. 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. There were surges in medicine, surgery, pediatrics and critical care. 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. Unfortunately, we did not 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%

Kingston General Hospital

Q4 FY2016 Strategy Performance Indicators Report

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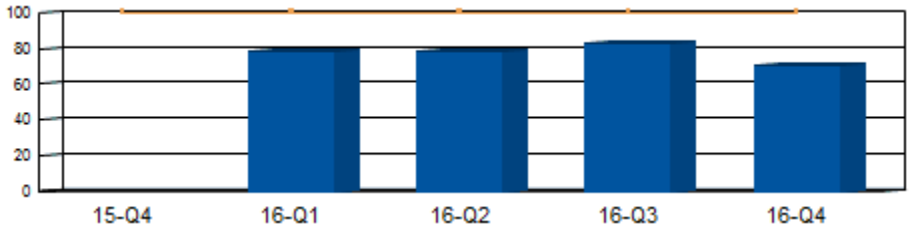
Indicator: Percent of Clinical Services (Excluding Cancer Surgery) Meeting or Exceeding Priority 4 Wait Time Target



	Actual	Target
15-Q4		**100**
16-Q1	78	**100**
16-Q2	78	**100**
16-Q3	83	**100**
16-Q4	70	**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 categories. The denominator consists of 58 surgical categories, 2 diagnostic imaging (DI) categories and 3 cardiac categories. For Q4, priority 4 cases 41 of the 58 (71%) surgical categories meet their target threshold. The breakdown of the 17 that did not is as follows: 3 Gyn Surg (adding to hysterctomy (Q3) are urinary incontinence and other gyn procedures) , 3 Neuro Surg (adding to anterior cervical and lumbar disc (Q3) is other neuro surg), 5 Ortho Surg (adding to hip replacement and other ortho surg (Q3) is knee replacement and anterior cervical and lumbar disc) , 2 Plastic Surg, 3 Urol Surg (adding to removal/destruction calculli (Q3) is partial excision prostate and urinary incontinence). and 1 Ped Ortho Surg. Neither of the 2 DI categories (CT & MRI) made the 90% target for priority 4 cases (MRI was 41% and CT was 71%). Of the 3 cardiac categories, all 3 meet the 90% target. Therefore, overall 44 of 63 (70%) clincial categories meet the 90% 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?

No. The sheer volume and lack of a second MRI continues to challenge the performance of this metric.

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

The Ontario Wait Time Strategy (WTS) measures the wait time from when a patient and surgeon decide to proceed with surgery, until the time when the actual surgical procedure is completed. This interval is typically referred to as from "decision to treat" to "treatment". For wait times that are reported for the specific time period, calculations include all cases where the surgery or ("treatment") was completed during that time period. The wait times are calculated by subtracting the "decision to treat" date from the "treatment" date, resulting in a wait time that is measured in days. Patients are assigned a priority score from 1 to 4 with 4 being the least urgent or most elective. Each priority score is assigned a target wait time by the MoH. For cases that fall into the priority 4 category a calculation of the percent of cases meeting that target wait time is done. The MoH has stated that hospitals should be meeting target wait times 90% of the time. This corporate indicator rolls together 63 various clincial categories to report overall adherence to the 90% target. It is intended to provide an overall view of progress with respect to meeting MOH wait time targets.

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

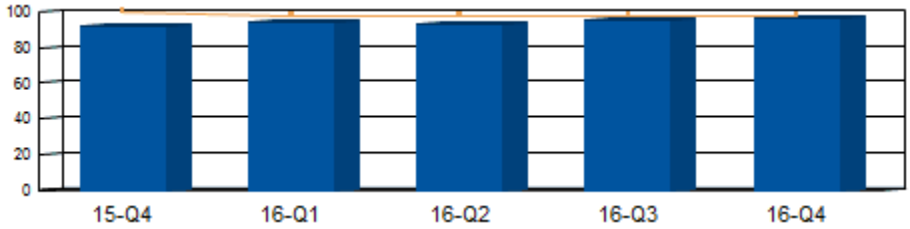
Kingston General Hospital

Q4 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-Q4	92	**100**
16-Q1	94	**98**
16-Q2	93	**98**
16-Q3	95	**98**
16-Q4	96	**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 continue training in H.E.A.R.T. (Hear, Empathize, Apologize, Respond, and Thank) 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. The steering group has evaluated the training and adapted it to an online learning module 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 January, February and March a total of 7111 audits were completed for 4 standards (ID badges, patient whiteboards, communication and hourly rounding). Of those total audits 6822 were in compliance or 96%. The individual standards are being reported at a corporate compliance rate of at least 93%. (Badges 96%, whiteboards 93%, 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 17 out of a possible 18 or 94%.
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?

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.

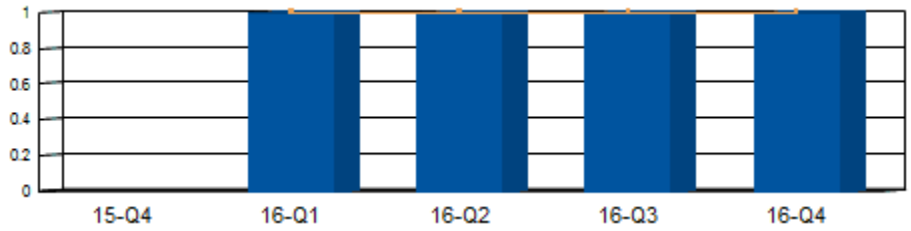
Target: Target 14/15: 100% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%,Target 15/16: 98% Perf. Corridors; Red <50% Yellow 50%-79% Green>=80%

Q4 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-Q4		
16-Q1	1	**1**
16-Q2	1	**1**
16-Q3	1	**1**
16-Q4	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 received approval from the MOHLTC to move forward to issue for tender which occurred in the fourth quarter. The tender bid is currently open until April 28, 2016. 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:

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. Stephen Scott's ground-breaking research into the assessment of brain injury is an example of the type of research that will be occurring in the new Centre once built in early 2017. The centre gives him the opportunity to integrate his paradigm-shifting KINARM technology and its growing library of new findings with the specific research needs of hospital clinician-scientists, ultimately leading to better care and quality of life for patients.

Kingston is in the unique position of being the only hospital community in North America with KINARM labs at all of its hospitals. It also puts it on a par with 14 other clinical research centres worldwide, including the Kennedy Krieger Institute at Johns Hopkins University, the Fukushima Medical University and the Max-Planck Institute for Human Cognitive and Brain Sciences at University of Leipzig, who are now using the leading-edge technology.

This robotic system for measuring human behaviour enables clinician scientists to characterize a patient's specific neurological impairments, design patient-centred therapies, identify subjects for their research protocols, and collect objective data on a patient's response to specific therapies.

Having the labs on-site in the hospitals allows doctors to follow their patients throughout their journey, from intensive care to rehabilitation. "It's about basic research going into clinical practice, and changing clinical practice," says Dr. Scott.

The value of the KINARM lab approach is reflected in the breadth of research being done by clinician scientists at KGH. At least 10 studies are currently being run, including research into the sensorimotor effects of sepsis, illness, cardiac surgery and related events, kidney dialysis, shoulder replacement surgery, Parkinson's disease and stroke.

"Steve Scott and his technicians have been amazing," says Dr. Gordon Boyd, a neurologist and critical care doctor who is studying the effects of cardiac arrest on brain function. "I just text them in the morning, tell them I need to use the KINARM, they get us in right away."

"It allows me to be a clinician in the ICU and then wheel my patients up here and do their neurological assessment with the KINARM. I couldn't possibly do that on my own."

Dr. Boyd's goal is to develop novel strategies and techniques to treat and prevent brain injury as a result of cardiac arrest.

This profile was written by KGHRI Communications Consultant 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?

Yes we are on track and met our target. We are still anticipating construction commencing in the second quarter of F2017 with the Centre opening up in the fourth quarter of F2017.

Q4 FY2016 Strategy Performance Indicators Report

Cultivate patient oriented research

Externally funded research at KGH has increased by 50%

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.

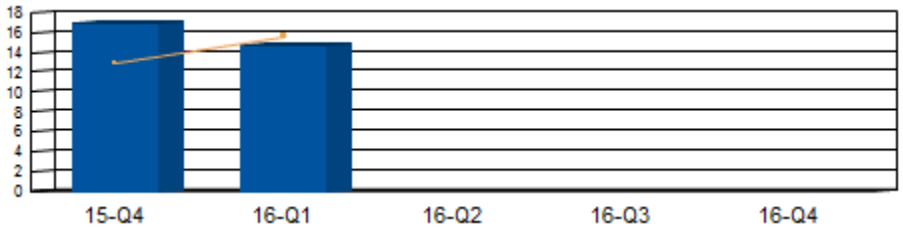
Target: Target 15/16: As per stated project milestones Perf. Corridor: Red 0 = No Yellow N/A Green 1=Yes

Q4 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-Q4	16.89	**13**
16-Q1	14.74	**16**
16-Q2		
16-Q3		
16-Q4		

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.

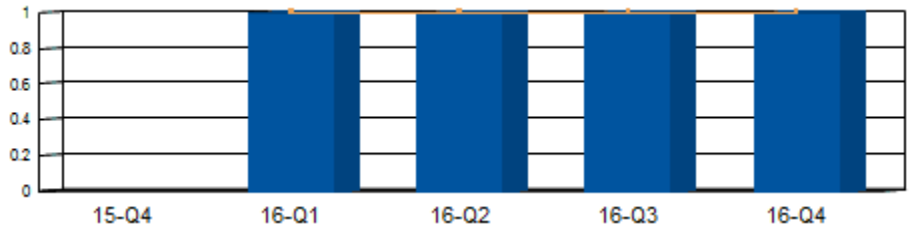
Target: Target 11/12: 12.9%, Target 12/13: 12.9%, Target 13/14: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 14/15: 12.9% Perf. Corridor: Red >18% Yellow 14.3%-18% Green <=14.2%, Target 15/16: Quarterly expected MOH rate Perf. Corridor: Red > 10% of expected Yellow plus 10% expected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

Q4 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-Q4		
16-Q1	1	**1**
16-Q2	1	**1**
16-Q3	1	**1**
16-Q4	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 Q4, we:
oRefreshed 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
oConducted stakeholder engagement to solicit feedback on our refreshed strategic directions (Jan. 15th leadership planning day, Feb 10th Board planning day, Strategy Advisory Council, Physician Leaders Forum, Team Talks & Council Conversations with over 60 teams participating)
oFinalized our 2016-17 Integrated Annual Corporate Plan and Quality Improvement Plan

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 achieved the 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 have achieved the target and the 2016-17 Integrated Annual Corporate Plan and Quality Improvement Plan are available at kgh.on.ca/strategy as a digital strategy and performance reporting product.

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)

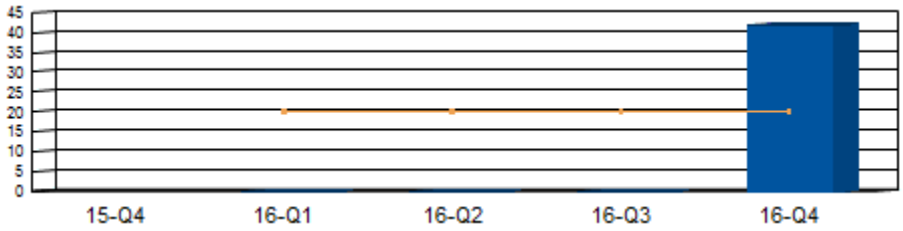
Kingston General Hospital

Q4 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-Q4		
16-Q1	0	**20**
16-Q2	0	**20**
16-Q3	0	**20**
16-Q4	42	**20**

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

The Staff and Physician Engagement Survey results were received as well as the Volunteer results in Q4. Corporate staff and physician results were shared. Discussions began with leaders and at the team level to understand and review results. This will continue into next year. We continue to build out our Leadership Innovation For Tomorrow (LIFT) strategy and components. The continuous learning policy was approved and a Continuous Learning Secretariat was formed to assist in reviewing training opportunities on a corporate level. Leadership Days were held with great success and included coaching one on one with 25 leaders in the quarter for skill building.

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 2013, one recommended area to build was the support for education and training for staff. The area of focus for corporate engagement relates to the question on the staff survey " Does the organization provide opportunities for employee education, learning and development?". The positive percentage score was 50.2%. An aggressive target of a 20% increase to bring us to 60.24% 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 target was met. The employee 2015 survey results show an actual increase of 42%, which brings the overall positive score on this question to equal 71.8%. This is better than the Ontario employee teaching hospital average of 65.2% and the Ontario all employee average of 61.9%. Although respondents that indicated that their training was paid for by the organization was a bright spot, scores on training to help do one's job better and stay up to date with job requirements are lower than in 2013. We are currently engaged in discussions with our leaders and staff to gain a better understanding of this metric.

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

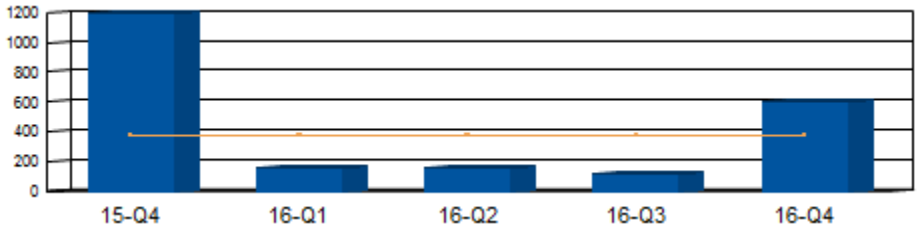
Kingston General Hospital

Q4 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-Q4	1,198	**375**
16-Q1	158	**375**
16-Q2	159	**375**
16-Q3	116	**375**
16-Q4	605	**375**

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

There were 605 completed performance plans in the quarter. Information sessions continued alongside regular communication and data sharing to ensure all leaders were informed of their status and progress toward the 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:

Performance conversations are linked to individual engagement and accountability. The emphasis is on development and learning supports to garner improved commitment of staff and a direct link with the KGH strategy. The performance target was 3000 in total broken out into 1500 in each of 2 years. 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?

We achieved 3,122 performance agreements in the 2 year period to exceed the target although more were completed in year 1 than in year 2 (2084 and 1038 respectively). The corporate employee engagement results demonstrated some improvements in the supervisor theme, and statistically significant increases in the ability to receive education and training, the supervisor helping to access training, as well as feedback on job performance. The performance review process is an important aspect of engagement and the intention for sustainment of these gains will be to continue to stay on track with conducting the performance conversations at least every two years with our employees.

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.

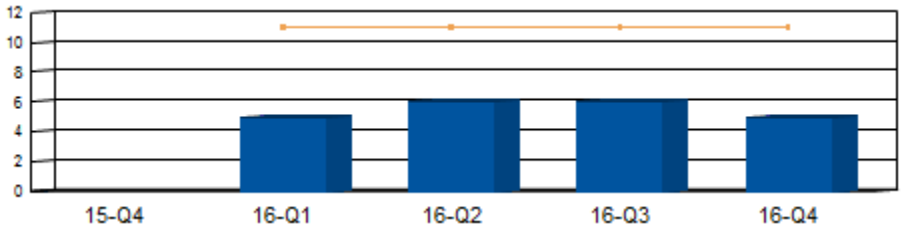
Target: Target 14/15; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375
Target 15/16; 1500 (375/Qtr.) Perf. Corridor: Red <338 or >413 Yellow 338-413 Green =375

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

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

In total, there were 19 injuries that occurred during patient handling activities. Of these, 5 resulted in health care claims; there were no lost time injury claims related to patient handling injury in Q4.

Over the course of the year then, we have seen a 31% reduction in MSIs caused by patient handling. While our goal for WSIB claims due to patient handling was a 20% reduction, we actually saw a 60% reduction with 22 claims down from 53 last year. Of these 22 claims, 20 were health care claims and 2 were lost time claims. The highest incidence of claims was in the Medicine Program (50% of claims) and the Critical Care Program (23% of claims).

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

Over the course of the year we have seen a 31% reduction in MSIs caused by patient handling. While our goal for WSIB claims due to patient handling was a 20% reduction, we actually saw a 60% reduction with 22 claims down from 53 last year. Of these 22 claims, 20 were health care claims and 2 were lost time claims. The highest incidence of claims was in the Medicine Program (50% of claims) and the Critical Care Program (23% of claims).

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 focus by the ergonomist on high injury units, there has been reduction of injury. This has included staff education/re-education and assessment of equipment needs with equipment purchases. The MSI continuous improvement plan, which came from our participation in the 2015-16 Safety Groups incentive program and identifies gaps/areas for improvement, will guide the work for the year ahead that will focus on working in collaboration with others (e.g. Falls Working Group), to achieve fewer patient falls and fewer staff injuries.

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.)

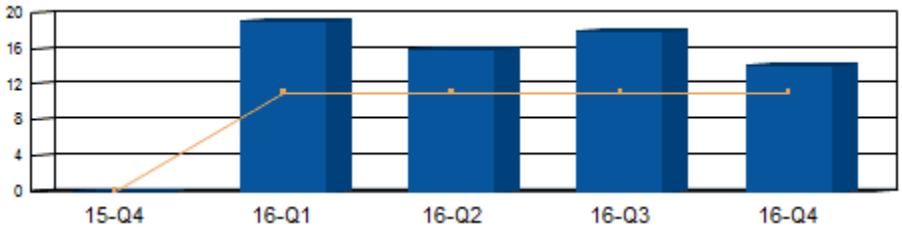
Kingston General Hospital

Q4 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-Q4	0	**0**
16-Q1	19	**11**
16-Q2	16	**11**
16-Q3	18	**11**
16-Q4	14	**11**

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

Out of 25 incidents reported, 14 staff indicated they had sustained an injury. Of this, 2 reported needing first aid or visiting occupational health, and 2 resulted in WSIB health care claims. Although our goal was a 20% reduction this year, we actually had a 20% increase in reported injuries. Of the 67 reported injuries, 16% (n=11) required first aid or visited occup. health, 13% (n=9) resulted in WSIB health care claims, and 1.5% (or 1 injury) resulted in 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:

Although our goal was a 20% reduction this year, we actually had a 20% increase in reported injuries. We are encouraging greater reporting to allow us to address root causes. Given the communications internally and externally regarding this issue, it has brought attention to the need for good reporting. Of the 67 reported injuries, 16% (n=11) required first aid or visited occup. health, 13% (n=9) resulted in WSIB health care claims, and 1.5% (or 1 injury) resulted in lost time. 37% of reported injuries occurred in the Mental Health Program, 33% in the Medicine Program, and 10% in the ED.

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

Tactics this year focused on improving compliance with the violence risk assessment included in the patient care record and activation of Behavioural Crisis Alerts (BCA) where criteria were met. The Violence Prevention Taskforce was active in overseeing a comprehensive action plan related to violence prevention that resulted in the implementation of many improvements. As of the end of Q4, over 300 clinical staff have been certified in Non-violent Crisis Intervention (NVCI) training with mental health program staff completing an annual refresher. Our focus in 2016-17 will be on the development of care plans/risk reduction plans for all patients with active BCAs and revision of the Code White Debrief process to maximize staff participation in risk reduction discussion and planning. In Q1 the Violence Prevention at KGH Guide for patient and families will be released, as will a Safety Talks Bulletin for clinical staff that reinforces prevention and management strategies for patient violence, including communication requirements. the risk reduction template which is already in use in mental health and is on trial on Kidd 7 and Kidd 4, will be reassessed for possible reapplication throughout the hospital. The Violence Working Group will continue in 2016-17 to ensure continued focus and improvement in relation to violence prevention.

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.

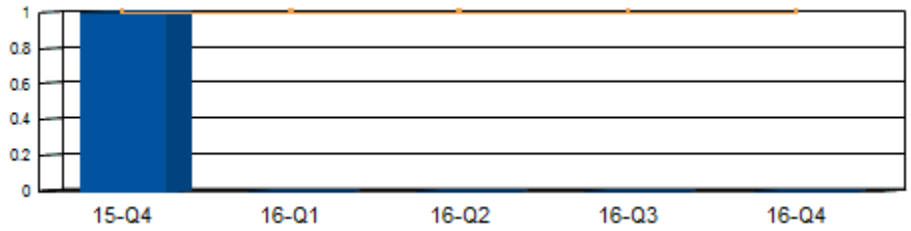
Target: Target 2015/16: 44(11/qtr) Perf. Corridor: Red >49(>13/qtr.), Yellow 45-49 (12-13/qtr.), Green <=44 (<=11/qtr.)

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

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

On 16 February 2016, the ministry sought clarification on 15 of the previously posed 69 questions. This clarification was provided on 9 March 2016. On 18 April the ministry sought further clarification on 2 questions. These are currently being worked on. In addition, the Deputy Minister, Bob Bell toured the priority areas on March 14th. He seemed supportive of the need to improve our deteriorating facilities. 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)

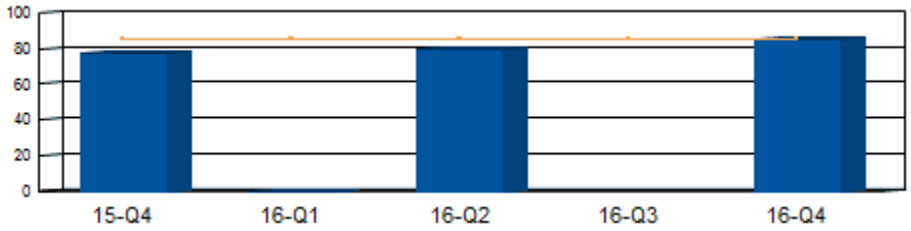
Kingston General Hospital

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

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

Duty list assignments for Environmental Services were implemented January 25th and minor adjustments were made throughout February and March. Supervisory capacity has been increased, and a system of daily audits by our supervisory team has been implemented as well as a process of identifying training issues. Any audits scoring below 85% will be immediately rectified. A monthly surprise "Mini Audit" (64 audits in a single day mimicking the official Westech Audit) will be conducted to take a temperature check of current state. Additional resources were added to the Emergency Department to rectify a consistent deficiency in this area.

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

Westech conducted an audit of KGH April 25th to 28th. Overall score was 85.07% which indicates that KGH has achieved the minimum standard to declare a clean hospital. Although a "Passing" score was achieved, several areas require immediate attention including ICU areas for example. More detailed analysis will be provided to the leadership team in mid may. "Mini Audits" will continue to be conducted each month to verify that we remain on 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?

Internal audits show trending below target; however we tend to audit ourselves more rigorously and with a smaller sample size focused on challenging areas. We will continue to audit rigorously both daily and with monthly mini-audits to ensure we remain on target.

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%

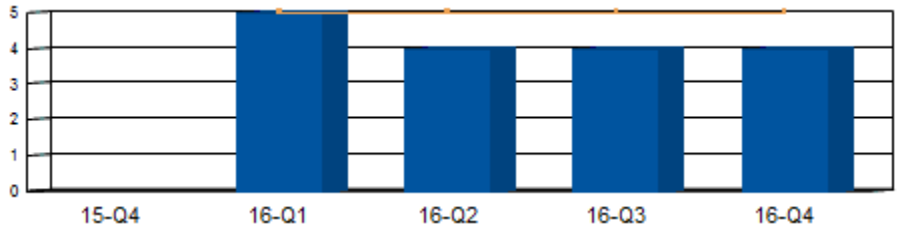
Kingston General Hospital

Q4 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-Q4		
16-Q1	5	**5**
16-Q2	4	**5**
16-Q3	4	**5**
16-Q4	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 fiscal year 2015. The final decision regarding the release of the HIS RFP is subject to the Healthcare Tomorrow timelines and the provincial HIS review. An external consultant was hired to complete the costing analysis for the technology.

2. Stage 1 of the South East LHIN cNEO Implementation project is coming to a close. The next step is for the CEO's to sign each hospital's Memorandum of Understanding (MOU) in order to begin the technical development for Stage 2. The change management phase continues to progress throughout all of the SE LHIN hospitals in order to build awareness around the project.

3. The Automated Chemistry Track project has completed 50% of the track validation process which is scheduled to complete on May 6th. Scheduled stress testing of the system is also underway and has yielded positive results thus far with only minor issues noted (those issues are scheduled to be resolved by mid-April). The track go-live is scheduled to take place from May 13th to May 15th.

4. The Intranet phase of the Web Redevelopment project is scheduled to begin on April 6th. The planning phase will follow throughout the month of April with the goal of identifying scope, strategies and resources for the project.

5. The Staff Scheduling and Time Capture project is in a 'Refresh' phase with the on-boarding of the remaining ~800 employees on hold. The Staff Scheduling Operations Committee will lead corrective actions for the 2,650 staff already on-boarded, and produce a plan for a go-forward strategy. Pilot projects have been proposed and planning is currently underway.

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 project 'refresh' with the on-boarding of the remaining ~800 employees on hold. A Staff Scheduling Operations Committee was assembled in Q4 to review the issues and develop process improvement plans.

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 with the exception of the Staff Scheduling and Time Capture (SSTC) project. SSTC will have a revised project plan that will most likely extend until the end of the calendar year based on the information at the time of this report.

NOTE: The HIS RFP, cNEO and Intranet 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

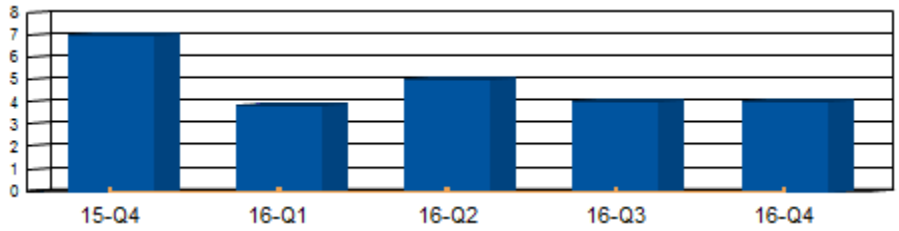
Kingston General Hospital

Q4 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-Q4	7.03	**0**
16-Q1	3.86	**0**
16-Q2	5.04	**0**
16-Q3	4.02	**0**
16-Q4	4.06	**0**

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

The hospital undertook a review of financial results at the end of Q3 with a view to projecting the year-end fiscal position. The year-end results were slightly more favourable than projected.

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 ended the year with a surplus of revenue over expenses, before building amortization, or approximately $18 million. $5 million of this favourable fiscal result was due to the recognition of higher than planned funding for specific patient care activity volumes. The remaining $13 million resulted from amounts provisioned from the operating budget to provide for capital expenditure.

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

Definition: DATA: J'Neene Coghlan COMMENTS: J'Neene Coghlan EVP: Jim Flett REPORT: STRATEGY REPORT

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

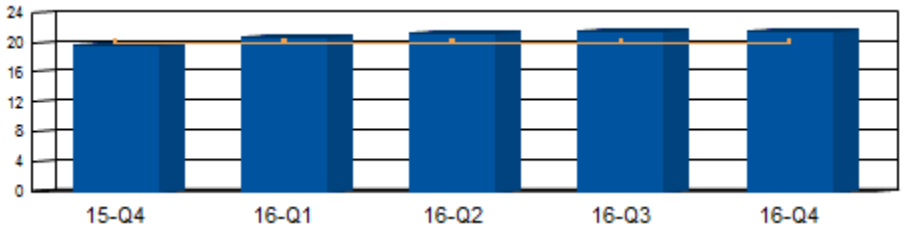
Target: Baseline 08/09: (3.9%), Target 09/10: (4.0), Target 10/11: (2.17), Target 11/12: 0, Target 12/13: 0, Target 13/14: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0, Target 14/15: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0, Target 15/16: 0% Perf. Corridor: Red <0 Yellow N/A Green >=0

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

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

The hospital 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, the Kingston General Hospital Auxiliary, and 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:

The fiscal 2016 capital investment capacity provided $21.4 million for the replacement of existing patient care equipment, technology and facilities infrastructure.

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

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

Q4 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