Capital Health

Capital Health’s Strategic Indicators Report
June 2014

Prepared for the Board of Directors and
The Quality and Patient Safety Committee of the Board

Prepared by Decision Support
June 20, 2014
Table of Contents and Indicator Summary

The indicators in this report are summarized in the table below. A short description of the current status is also provided. Note the icons below used in the summary under the “Target” column. A summary of indicators related to patient safety can be found in Appendix A and a summary of indicators related to access (wait times) can be found in Appendix B. Appendix C will provide a summary of the progress of the 14 Areas of Focus when progress measures become available.

- Meeting target or on track to meet target
- Not meeting or will not meet target
△ Caution – needs work to meet target
△ Trending toward target
B Baseline measure only
◆ Being tracked but with no established target or standard.

* Click on an indicator name to go directly to that section *

<table>
<thead>
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<th>Target</th>
<th>Indicator Name</th>
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<tr>
<td>⚫</td>
<td>Surgery Cancellation Rates</td>
<td>Met target in Feb. but went above target (unfavourable) in March. The April rate was very high due to a nursing strike.</td>
<td>8</td>
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<tr>
<td>⚫</td>
<td>Wait Times – Elective CT</td>
<td>The April 2014 wait time was 31 days—just longer than the target of 28 days</td>
<td>10</td>
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<td>⚫</td>
<td>Wait Times – Elective MRI</td>
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<tr>
<td>✔️✔️</td>
<td>Wait Times - Radiotherapy Treatment</td>
<td>In April 2014, radiotherapy wait times were meeting target for urgent cases but not for intermediate cases.</td>
<td>12</td>
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<td>⚫</td>
<td>Wait Times – Hip Fracture Surgery</td>
<td>In Q4 of 2013/14, only 67% of cases met the target wait time.</td>
<td>14</td>
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<td>⚫</td>
<td>Wait Times – Hip Replacement</td>
<td>In Q4 of 2013/14, only 62% of cases met the target wait time.</td>
<td>15</td>
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<tr>
<td>⚫</td>
<td>Wait Times – Knee Replacement</td>
<td>In Q4 of 2013/14, only 35% of cases met the target wait time.</td>
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<tr>
<td>⚫</td>
<td>Wait Times – Cataract Surgery</td>
<td>In Q4 of 2013/14, only 73% of cases met the target wait time, but there has been an increasing trend in the past several quarters.</td>
<td>17</td>
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<tr>
<td>✔️✔️</td>
<td>Wait Times – Open Heart Surgery</td>
<td>In April 2014, the target was met for scheduled and semi-urgent cases, but urgent cases were over target.</td>
<td>18</td>
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<tr>
<td>⚫</td>
<td>Wait Times – From Triage to Admission in the Emergency Department</td>
<td>Both the QEII and DGH are above the target of 8 hours for the 90th percentile wait time.</td>
<td>19</td>
</tr>
<tr>
<td>✔️</td>
<td>Wait Times – From Triage to Physician in the Emergency Department</td>
<td>None of the four sites is meeting the target of 30 minutes.</td>
<td>20</td>
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### Patient Safety Indicators

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<tr>
<td>✔️</td>
<td>Transmission Rates – MRSA</td>
<td>The transmission rates at CDHA are far below the 2011 national incidence rate.</td>
<td>21</td>
</tr>
<tr>
<td>✔️</td>
<td>Incidence Rate – VRE</td>
<td>The rates at CDHA are below the 2012 national rate.</td>
<td>22</td>
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<tr>
<td>✔️</td>
<td>Infection Rate – C. difficile</td>
<td>The rates at CDHA are below the 2012 national rate.</td>
<td>23</td>
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<tr>
<td>✔️เย่</td>
<td>Hand Hygiene Compliance</td>
<td>For Jan–Mar 2014, the “before patient/patient environment contact” rate was 65%—short of the target of 80%. The “after” rate was 81%—better than the target of 80%.</td>
<td>24</td>
</tr>
<tr>
<td>✔️เย่</td>
<td>Hospital Standardized Mortality Ratio</td>
<td>For Q1–Q3 2013/14 CDHA’s HSMR showed no statistically significant difference from the 2009/10 national average.</td>
<td>25</td>
</tr>
<tr>
<td>✔️เย่</td>
<td>Patient Experience Survey</td>
<td>In 2012/13, the positive response target of 90% was exceeded in five out of eight dimensions.</td>
<td>26</td>
</tr>
<tr>
<td>💡</td>
<td>Patient Safety Culture</td>
<td>No target set. The 2012 survey shows improvement over 2010.</td>
<td>27</td>
</tr>
<tr>
<td>✗เย่</td>
<td>Completion of Patient Safety Training</td>
<td>For 2013/14, 40% completed at least one patient safety training course. This is short of the target of 100%</td>
<td>28</td>
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### Additional Transforming Person-Centred Health Care Experience Indicators

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<td>✗เย่</td>
<td>Length of Stay – Number of Conservable Days</td>
<td>For the full 2013/14 fiscal year, conservable days totaled 6,223. This is an improvement over the past three years but just short of the target of 6,188 (unfavourable).</td>
<td>29</td>
</tr>
<tr>
<td>✔️เย่</td>
<td>Occupancy Rates</td>
<td>For 2013/14, the DGH occupancy rate was above the target of 90% (unfavourable), but the rate for the QEII was 89.1%—just below the target (favourable).</td>
<td>30</td>
</tr>
<tr>
<td>✗เย่</td>
<td>Emergency Department – Left Without Being Seen</td>
<td>All sites are over the 2% target except Hants.</td>
<td>32</td>
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<tr>
<td>☢️</td>
<td>Long Term Care – Patients Placed &amp; Waiting to be Placed</td>
<td>In March 2014, there were 77 patients waiting to be placed. This is very close to the target of 75.</td>
<td>33</td>
</tr>
<tr>
<td>⭕️</td>
<td>Strengthen Community-Based Care for Chronic Disease</td>
<td>Baseline measurement only at this time</td>
<td>35</td>
</tr>
<tr>
<td>⭕️</td>
<td>Improve Quality of Care in Transitions</td>
<td>Baseline measurement only at this time</td>
<td>36</td>
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<td>⭕️</td>
<td>Build a Culture of Customer Service</td>
<td>Baseline measurement only at this time</td>
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### Citizen and Stakeholder Engagement and Accountability

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<td>⭕️</td>
<td>Partner with the Public so Individuals and Communities can Play a Key Role in Managing Their Own Health</td>
<td>Baseline measurement only at this time</td>
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<td>⭕️</td>
<td>Involve Patients Directly in Their Care</td>
<td>Baseline measurement only at this time</td>
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<td>⭕️</td>
<td>Lead Dialogue with the Public Addressing Appropriateness of Care</td>
<td>Baseline measurement only at this time</td>
<td>40</td>
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<td></td>
<td><strong>Transformational Leadership</strong></td>
<td></td>
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<tr>
<td>✗</td>
<td>Absenteeism</td>
<td>For 2013/14, there were 6.82 average monthly paid sick hours per employee. This is an improvement over recent years but is short of the target of 6.15. There was an improvement in April 2014 to a rate of 6.48.</td>
<td>41</td>
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<tr>
<td>✔</td>
<td>Overtime</td>
<td>The rate was below target (favourable) for the 2013/14 fiscal year. The April 2014 rate was also better than the target.</td>
<td>42</td>
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<td>✤</td>
<td>Employee Survey</td>
<td>Pride, trust in peers, &amp; spiritual wellness are areas to celebrate. Areas for improvement include psychological safety, involvement in decision making, &amp; trust in management.</td>
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<tr>
<td>✤</td>
<td>Employee Survey – Accreditation Canada Worklife Pulse</td>
<td>Employee ratings of ‘job satisfaction’ and ‘clarity about expectations’ remained high for 2012. However, there were slight increases in the number of ‘unfavourable’ responses in almost all dimensions</td>
<td>44</td>
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<td>✤</td>
<td>Physician Survey</td>
<td>Of the 6 sections presented, trust in colleagues and respect had the highest percentage of favourable responses, while trust in Capital Health management and engagement with Capital Health had the lowest.</td>
<td>45</td>
</tr>
<tr>
<td>B</td>
<td>Improve Leadership Capacity at all Levels</td>
<td>Baseline measurement only at this time</td>
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<tr>
<td>B</td>
<td>Strengthen Accountability of Employees and Physicians.</td>
<td>Baseline measurement only at this time</td>
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<td><strong>Innovating Health and Learning</strong></td>
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<td>✤</td>
<td>Research Funds from Grants &amp; Contracts</td>
<td>For 2012/13, both grants and contracts were down from the previous year.</td>
<td>48</td>
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<td>B</td>
<td>Focus on Innovation that has Benefits for Patients &amp; Aligns with Our Mission.</td>
<td>Baseline measurement only at this time</td>
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<td>B</td>
<td>Strengthen Partnerships with Learning Institutions</td>
<td>Baseline measurement only at this time</td>
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<td>B</td>
<td>Build our Capacity for Interprofessional Research and Interprofessional Education</td>
<td>Baseline measurement only at this time</td>
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<td><strong>Sustainability</strong></td>
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<td>✗</td>
<td>Innovate Systems and Processes for Greater Efficiency</td>
<td>For the 2013/14 fiscal year, the percentage of typical cases for the three CMGs with an ALOS equal to or less than the ELOS was 48%—short of the target of 52%</td>
<td>52</td>
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<td>B</td>
<td>Develop Funding Models Based on our Priorities</td>
<td>Baseline measurement only at this time</td>
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Introduction

Capital Health’s Strategic Indicators Report is a stimulus for quality improvement as it provides multi-year data on key indicators identified by Capital Health stakeholders. Over the summer and fall of 2009, leaders within Capital Health were asked to identify strategic indicators which would aid in their work to fulfill “Our Promise” to become a world-leading haven for people-centred health, healing, and learning. This process resulted in the creation of the Capital Health Indicator Development document which itemizes indicators by five Strategic Streams:

1. Transforming Person-Centred Health Care Experience
2. Sustainability
3. Transformational Leadership
4. Citizen and Stakeholder Engagement & Accountability
5. Innovating Health & Learning

Appendix C provides a detailed description of the strategic streams. Indicators in this report fall under these five streams.

The Quality and Patient Safety Framework is also based around these five strategic streams (Appendix D) (as well as the eight Qmentum Quality Dimensions outlined by Accreditation Canada).

The Our Promise Milestones timeline came to an end in March 2013 and the final reporting on their progress was done in the July 2013 version of this report. Even though the time frame for the Milestones has ended, several of the milestones are being carried forward in this report for continued monitoring.

Strategic Plan Renewal: Beyond 2013

With the input of hundreds of patients, family members, citizens, staff and physicians, Capital Health’s strategic plan has been renewed for the next three years (2013 to 2016). The renewed plan, entitled “Our Promise in Action,” remains anchored around the same five key streams or strategies mentioned above.

Details surrounding these five strategies, as well as the 14 Areas of Focus within the strategies, are outlined in the “Our Promise in Action” poster which can be found in Appendix E. The 14 areas of focus are presented in this report under their own section. So far, only baseline measures are presented. When some measureable progress is available, it will be summarized in a table in Appendix F.

For additional information on Capital Health’s “Our Promise in Action”, please visit the Capital Health website at http://www.cdha.nshealth.ca/our-promise-action
Indicator Sections

Each indicator in this report is summarized by answering the following four questions:

1. What is being measured?
2. Why is it important?
3. How are we doing?
4. What are we doing about this?

As this is a new format for the report, not all indicator sections yet have information for each of the four questions. This will be added as the information is collected. Progress for each indicator is also shown visually on an accompanying graph.

As well, the following icons appear at the top of selected indicator pages:

The **Patients First** icon specifies a **patient safety** indicator.

The **Our Promise in Action** icon specifies an **Area of Focus** indicator.

This report provides a consistent set of key strategic indicators and an analysis of the results. All indicators will be reported in each publication, although some indicators will be updated less frequently. For example, data regarding research funds from grants and contracts are updated annually; however, the indicator will remain in each publication. This will ensure regular, consistent access to key strategic indicators. Where possible, indicators are reported at the district level to provide an overall picture of district-wide activities. The Capital Health Strategic Indicators Report will be posted on the Capital District Health Authority’s website to ensure easy and broad access.

High level, overview summaries of patient safety indicators and access (wait times) indicators are provided in Appendices E and F respectively. The most recent measures as well as colour coding with respect to meeting targets are provided.

Data Quality and Revisions

The numbers presented in the graphs, tables, and narratives of this report come from a variety of sources. Every effort is made to ensure the data are accurate at the time of publication. Each publication only provides updated data for the most recently available time periods. Data from past time periods are not revised each time the report is published, so changes or corrections made to historical source data are not reflected in this report. Historical changes are carried over to the report when indicator definitions or data collection methods are changed. It should be noted that when such changes are made, they are not made to older versions of this report.
External Links

This report may provide links to other Internet sites only for the convenience of readers. Capital Health is not responsible for the availability or content of these external sites and cannot guarantee that the information is current or accurate. This information is provided as a public service. Readers should verify the information before acting on it. Capital Health does not endorse, warrant or guarantee the products, services or information described or offered at any other Internet sites. Capital Health does not assume and is not responsible for any liability whatsoever arising from the linking to any linked website, the operation or content (including the right to display such information) of any linked website, or for any of the information, interpretation, comments, or opinions expressed in any linked website. Any comments or inquiries regarding the linked websites are to be directed to the organization operating the website.

Contributors

This report would not be possible without the contributions of data, background information, and insights provided by many people at Capital Health. Those who are to be acknowledged for their valued contributions are listed in Appendix G.
1 Transforming Person-Centred Health Care Experience

Access Indicators

1.1 Surgery Cancellation Rates

What is being measured?
Cancelled surgeries are classified into two categories: 1) those cancelled for reasons originating in the hospital (resource related or preventable) and 2) those cancelled for reasons originating from the patient.

The cancellation rate (%) is calculated by dividing the number of patient- or hospital-related cancellations by the total number of elective surgical cases and then multiplying by 100.

The Our Promise: 2013 Milestone was to decrease preventable (resource-related) cancellations by 50% by 2012/13 (target of a 1.8% cancellation rate). January 2010 is the baseline time period when there was a cancellation rate of 3.4%.

How are we doing?
The graph below shows monthly cancellation rates for the most recent two-year period. The rate of resource-related cancellations has been higher than target since December 2012, but dipped below target in February 2014. In March, the rate went back to being higher than target. In April the resource-related cancellation rate shot up to 10.6% because of the nursing strike that took place.

The major contributing factor was strike related cancellation (totaled 235 cases across CDHA). When strike related cancellations are removed in April the resource related percentage changes to 2.6%. The second contributing factor (29 cases) was lack of elective time evenly distributed across VG/VG/DGH. Emergency bumps occurred for 20 cases.

DGH had 7 cases cancelled related to surgeon not available (7 cases, 1 service)

What are we doing about this?
Any OR time that becomes available is realigned to services with high trauma/ emergency volumes

Monthly meetings are held with the perioperative management team at which time case cancellations are reviewed to ensure there is prompt action to address the influencing factors.

[Text last updated June 2014]
Patient- and Hospital-Related Surgical Cancellation Rates & Total Surgeries for Recent Months

<table>
<thead>
<tr>
<th>Facility</th>
<th>March 2014</th>
<th>April 2014</th>
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<tbody>
<tr>
<td></td>
<td>Patient-Related Cancellations</td>
<td>Resource-Related Cancellation</td>
</tr>
<tr>
<td>HI</td>
<td>1.0%</td>
<td>2.5%</td>
</tr>
<tr>
<td>VG</td>
<td>3.2%</td>
<td>1.6%</td>
</tr>
<tr>
<td>DGH</td>
<td>5.1%</td>
<td>2.9%</td>
</tr>
<tr>
<td>HCH</td>
<td>1.1%</td>
<td>1.1%</td>
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Frequency of Data Updates: Monthly  Data Last Updated: June 2014  Next Data Update Expected: July 2014
1.2 Wait Times – Elective CT

What is being measured?
Computed tomography (CT) is a special radiographic technique that uses a computer to assimilate multiple x-ray images into a two-dimensional cross-sectional image. This can reveal many soft tissue structures not shown by conventional radiography. Scans may also be dynamic in which movement of a dye within the body is tracked.

This indicator is the weighted average wait time for elective CT (weighted as 23% cranial, 7% spine, 19% chest, 25% musculoskeletal and 25% abdominal).

Why is it important?
In order to support the health and wellbeing of our community, it is critical to provide timely access to supportive diagnostic procedures. Capital Health is committed to reducing wait times and providing better health care for you and your family. Shorter wait times are important to you and it’s a priority for us. CT scans serve a very important role in the identification and proper diagnosis of many health conditions. Early access to diagnostic services allows health providers to make timely decisions about further care options and can make a real difference in the outcome for the patient.

How are we doing?
The graph below shows the wait times and patient volumes for elective CT at Capital Health. This is the average for the QEII, Dartmouth General, and the Cobequid Community Health Centre combined. The target wait time is 28 days. The April 2014 wait time was 31 days—just over the target of 28 days.

To see recent wait times for elective CT at all locations in Nova Scotia click here.

What are we doing about this?
Capital Health continues to work to reduce wait times for CT exams. Capital Health received funding from the Department of Health and Wellness to replace an end-of-life CT scanner at the Victoria General site of the QEII. The new scanner began operation March 24, 2014 and should help to improve the care for patients at the Victoria General Hospital.

[Text last updated March 2014]
1.3 Wait Times – Elective MRI

What is being measured?
Magnetic Resonance Imaging (MRI) is a special imaging technique used to image internal structures of the body, particularly the soft tissues. MRI uses a powerful magnet, radio frequency waves, and computers to produce detailed images of the body in any plane. It provides much greater contrast between the different soft tissues of the body than does computed tomography (CT).

The average time from referral until procedure is weighted (72% neuro, 15% bone, and 13% body). Waits do not include QEII patients who have elective MRI procedures performed at the IWK. The target wait time is 28 days.

Why is it important?
In order to support the health and wellbeing of our community, it is critical to provide timely access to supportive diagnostic procedures. Capital Health is committed to reducing wait times and providing better health care for you and your family. Shorter wait times are important to you and it’s a priority for us. MRI scans serve a very important role in the identification and proper diagnosis of many health conditions. Early access to diagnostic services allows health providers to make timely decisions about further care options and can make a real difference in the outcome for the patient.

How are we doing?
In April 2014, the average wait time for MRI was 264 days—over 9 times longer than the target of 28 days.

All requests for MRI exams are triaged by radiologists for appropriateness and urgency level.

Over the last 6 months there has been a struggle to fill vacancies left by retirements and staff moving to other positions.

To see recent wait times for elective MRI at locations in Nova Scotia click here.

What are we doing about this?
All of the vacant MR positions have now been filled. New staff is being oriented to Capital Health and we will see increased capacity in early April 2014. As well, Dalhousie University implemented an MRI Specialty Practice Program in July 2013 and the first student is expected to graduate from the program in May 2014.

[Last updated March 2014]
1.4 Wait Times - Radiotherapy Treatment

What is being measured?
This indicator measures the wait time, in days, from date of receipt of referral for radiation therapy to the date that the treatment starts. Values shown are the average wait times for a one-month period.

Why is it important?
In radiotherapy (also called radiation therapy), high-energy photons are used to damage cancer cells and stop them from growing and dividing. Target wait times for radiotherapy treatment are based on acuity level. Patients are assigned to an acuity level based on assessment by a radiation oncologist, a specialist in radiation therapy.

Examples of criteria for intermediate cases are inpatients in hospital for radiation services or patients having head and neck tumors. Subacute neurological dysfunction, tumor hemorrhage or severe uncontrolled pain are examples of cases requiring urgent radiotherapy.

How are we doing?
The two graphs below show the average monthly wait times for patients in the urgent and intermediate categories. Patient volumes are also shown.

Wait times for urgent cases have been below the target (favourable) for June 2013 to April 2014, except for in January 2014, when the wait time went slightly higher than the target. In early January, flooding in the Dickson Building affected the CT simulator used for radiotherapy treatment planning and likely contributed to this increase in wait times.

Wait times for intermediate cases have been consistently longer than the target of 14 days, but have been less than 21 days for almost the past two years with the introduction of new equipment. The January 2014 average wait time showed a slight increase to 20.70 days which would also be a result of the flooding mentioned above. The April 2014 wait time was 17 days.

To see recent wait times for radiotherapy treatment at locations across Nova Scotia click here.

What are we doing about this?
The opening of the James and Edna Claydon Radiation Therapy Clinic in October 2012 has provided additional radiation therapy capacity along with state of the art radiation therapy equipment. With the implementation of all of the new equipment by end of April 2013, it is expected wait times for intermediate and standard cases will decrease over this fiscal year.

The new radiotherapy machines are more technologically advanced with better imaging. This will allow a decrease in patient treatment time along with a decrease in the number of fractions per patient, which means more patients can be treated and many patients will be on treatment for a shorter time. In addition, several process improvements, as well as an electronic medical record, have been implemented to reduce wait times. [Last updated April 2013]
Wait Times and Patient Volumes for Radiotherapy Treatment - Urgent

Wait Times and Patient Volumes for Radiotherapy Treatment - Intermediate

Frequency of Graph Updates: Monthly  Graphs Last Updated: June 2014  Next Graph Update Expected: July 2014
1.5 Wait Times – Hip Fracture Surgery

What is being measured?
This indicator is the percentage of patients who have fractured their hip and received repair surgery within the national benchmark target of 48 hours. Hip fracture repair is a procedure to fix a fracture of the femur bone (thigh bone) near the hip joint. The majority of cases are due to a fall or minor trauma in a person with weakened osteoporotic bones.

Why is it important?
When a patient fractures their hip, clinical evidence shows patients have better clinical outcomes if surgical repair of the hip fracture takes place within 48 hours. The national benchmark for hip fracture repair is 48 hours.

How are we doing?
The target is to have 100% of all cases of hip fracture repair receive their surgery in 48 hours. In Q4 of 2013/14, only 67% met the target (see graph below). At Dartmouth, for Q1–Q3 of 2013/14, the average was 93%.

What are we doing about this?
Several strategies are in place to increase the number of patients with hip fractures who receive surgery within 48 hours. These include:
- Meeting was held with key stakeholders to review processes and opportunity for improvement. Action items have been identified:
  - Review pre-op days as this appears to be driving time between admission & surgery
  - Review of mortality rates which has been initiated
- Any last minute available OR time is being realigned to support orthopedic trauma
- Inpatient Ortho Leadership meetings take place on a monthly basis (with the managers and Dr. Amirault) during which discussions take place related to long-stay patients, challenges with discharges, resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community.

[Last updated June 2014]
1.6 Wait Times – Hip Replacement

What is being measured?
Hip replacement is a surgical procedure in which the hip joint is replaced by a prosthetic implant. This procedure is generally done to relieve arthritis pain, or fix severe physical joint damage as part of hip fracture treatment. Measuring the time between when the orthopedic surgeon confirms the patient requires a hip replacement to the time the patient undergoes hip replacement surgery (wait time) is an important indicator of access to healthcare services. The national benchmark for wait time for hip replacement surgery is 182 days.

Why is it important?
National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for such a procedure. Over the past decade wait times for several surgical procedures such as hip replacement surgery have become a focus of Canadian healthcare as these wait times are a means of measuring access to healthcare services for Canadians.

How are we doing?
The graph below shows the percentage of patients who had their hip replacement surgery within the target wait time of 182 days. The target is to have 100% of hip replacement surgeries completed within this target time. In Q4 of 2013/14, only 62% of patients had their surgery within the benchmark of 182 days.

To see recent wait times for hip replacement surgery at different locations across Nova Scotia click here.

What are we doing about this?
Several strategies are being undertaken:
- A proposal for 2014/15 joints was submitted to the Department of Health and Wellness. Unable to deliver additional joints in Q1 and Q2 2014/15 due to nursing & anesthesia resource challenges.
- A team gets daily updates on the waitlist and what can be completed that day. This continues on the units to ensure discharges are done in a timely manner.
- Ortho Leadership meetings take place on a monthly basis (with the managers and Dr. Amirault) during which discussions take place related to long-stay patients, challenges with discharges, resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community.

[Text last updated June 2014]
1.7 Wait Times – Knee Replacement

**What is being measured?**
Knee replacement is a surgical procedure in which the weight-bearing surface of the knee joint is replaced to relieve the pain and disability of osteoarthritis. Measuring the time between when the orthopedic surgeon confirms the patient requires a knee replacement to the time the patient undergoes the surgery (wait time 2) is an important indicator of access to healthcare services. The national wait time benchmark for knee replacement surgery is 182 days.

**Why is it important?**
National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for such a procedure. Over the past decade wait times for several surgical procedures including knee replacement surgery have become a focus in Canadian healthcare as these wait times are a means of measuring access to healthcare services for Canadians.

**How are we doing?**
The graph below shows the percentage of patients who had their knee replacement surgery within the target wait time of 182 days. The target is to have 100% of all patients’ knee replacement surgery performed within 182 days. In Q4 of 2013/14, only 35% of patients had their knee replacement surgery within the target time frame.

To see recent wait times for knee replacement surgery at different locations across Nova Scotia click [here](#).

**What are we doing about this?**
Several strategies are being undertaken:
- Between November 2013 & March 2014 a total of 130 additional hip/knee joint patients that were long waiters were completed. This is 35 above target
- Proposal for 2014/15 joints was submitted to the Department of Health and Wellness. Unable to deliver additional joints in Q1 and Q2 due to nursing & anesthesia resource challenges
- A team gets daily updates on the waitlist and what cases can be completed that day. This continues on the units to ensure discharges are done in a timely manner.
- Ortho Leadership meetings take place on a monthly basis (with the managers and Dr. Amirault) during which discussions take place related to long-stay patients, challenges with discharges, resident rounds for each of the three units ensuring accuracy of discharge orders, prescriptions, and care that may be required upon discharge in the community.

[Text last updated June 2014]
1.8 Wait Times – Cataract Surgery

What is being measured?
Cataract surgery is the removal of a clouded lens (or cataract) from the eye to improve vision. The nationally recognized benchmark wait time for cataract surgery is 16 weeks. This indicator is the number of patients who had their procedure done in a given quarter who waited less than or equal to the national benchmark time frame, divided by the total number of patients who had the procedure completed in the given month, multiplied by 100.

Why is it important?
National benchmarks express the amount of time that clinical evidence shows is appropriate to wait for a procedure. Over the past decade, wait times for several surgical procedures, including cataract surgery, have become a focus in Canadian healthcare because these wait times are a means of measuring access to healthcare services for Canadians.

How are we doing?
The goal is to have 100% of patients have their cataract surgery within the benchmark wait time of 16 weeks. The graph below shows the quarterly percentages of patients who had their cataract surgery within the benchmark wait time. In Q4 of 2013/14, the rate was 73%. Over the past several quarters, there has been a trend of improvement.

To see recent wait times for cataract surgery at different locations across Nova Scotia click here.

What are we doing about this?
OR efficiencies have resulted in the ability of the clinical team to increase the number of cataract surgeries performed per room per day. The data below demonstrate this has been effective in increasing the number of cataract surgeries being performed within the target timeline.

[Last updated June 2014]
1.9 Wait Times – Open Heart Surgery

What is being measured?
This indicator is the median wait time for coronary artery bypass graft (CABG) procedures. Median wait time is the time half of the patients waited for their procedure.

Why is it important?
The chances of dying or having a heart attack increase as wait times exceed standards. Longer wait lists impact on the quality of life for patients awaiting surgery. An article published August 21, 2001 in the Canadian Medical Association Journal found a significant decrease in physical and social functioning, both before and after surgery, for patients waiting more than three months for their surgery. Patients waiting greater than three months also had a higher perioperative event rate than those waiting less than three months. Longer wait lists are associated with reduced likelihood of returning to gainful employment and thus lost productivity to society.

How are we doing?
Median wait times for CABGs are shown in the graph below. The median wait time for urgent cases has fluctuated widely over the past few months but was just over target for March and April 2014.

The median wait times for scheduled cases have been better than target since May 2013. Several patients who no longer needed to be on the list were removed that month.

Semi-urgent cases have been fluctuating above and below the target for the past several months. Most recently, in April 2014, the median wait time was 19 days—better than the target of 21 days.

What are we doing about this?
Bed capacity is the most challenging factor affecting these wait times. Options for managing long-term ventilated patients and model of care for ICUs are being explored.

[Last updated February 2014]
1.10 Wait Times – From Triage to Admission in the Emergency Department

What is being measured?
This indicator is the 90th percentile emergency department (ED) wait time from the time of triage to the time of admission. The 90th percentile wait time is the time in which 90% of patients wait. Clinical Decision Unit patients are not included.

Why is it important?
In 2010, the Institute of Clinical Evaluative Sciences identified the ED 90th percentile length of stay for admitted patients as the most important strategic indicator for quality in the ED and as a surrogate marker of overall hospital functioning.

Patients waiting in the ED for admission to an inpatient unit increase the overall ED wait times, the percentage of patients leaving the ED without being seen, and ambulance offload intervals, and are also associated with increased adverse events, mortality, inpatient lengths of stay, and overall costs.

How are we doing?
The goal is to have the 90th percentile wait time meet the target of eight hours. See the graph below.

For additional emergency-department indicators, click here to go to the CDHA ED Quarterly Performance Reports web page.

What are we doing about this?
Since January 2012 the staffing levels at the DGH ED have slowly improved. In the spring of 2012, various initiatives to focus on improving wait times were implemented: 1) a nurse liaison role was implemented which provides a second assessment point for patients in the waiting room. This nurse begins to complete blood work and ECGs for patients ensuring test results are available when the patient is seen by the physician. 2) An Offload Team staffed by a nurse and paramedic has been implemented to offload ambulances and allow them to get back into the community. The Offload Team begins care for patients and there are times when more acutely ill patients are seen by the physician in this area before beds are available. 3) In October of 2013, a new process for transferring admitted patients and their information to inpatient units was implemented which should significantly decrease the time it takes for patients to leave the department when inpatient beds are assigned.

The Flow Committee continues to look at flow within the ED and make changes to how beds are filled and how patients no longer requiring beds can receive follow-up care in alternative locations, thus freeing beds for those who need them.

The following changes have been implemented at the HI ED:
- Expansion of the patient flow manager role to 7 days a week
- Wait times & patients leaving without being seen are addressed by having Pod 5 open 24/7 since Sept. 2013. The care model now includes CTAs to allow flex in the system to increase bed capacity as necessary.
- Off-load initiatives continue to reduce off-load times
- Expansion of the Rapid Assessment Area to include weekend access
- District initiation for ambulance smoothing
- Collaboration with services for rapid access clinics i.e., atrial fibrillation and TIA’s
- Protocols in place for stroke and STEMI access and care

[Last updated November 2013]
1.11 Wait Times – From Triage to Physician in the Emergency Department

What is being measured?
This indicator is the average emergency department (ED) wait time from the time of triage to the time seen by a physician for Canadian Triage and Acuity Scale (CTAS) level III cases only.

Why is this important?
CTAS Level III cases are considered urgent because they could potentially progress to a serious problem.

How are we doing?
The graph below shows the average wait times from triage to physician for CTAS Level III for the last three years. A breakdown by ED site is provided. The target time is 30 minutes. All sites have wait times longer than the target of 30 minutes.

At Hants, wait times are a result of admissions remaining in the ED due to inpatient beds being at capacity, increased time to consult/tertiary care, and having only a single ED physician.

For additional ED indicators, click here to go to the Capital Health ED Quarterly Performance Reports web page.

What are we doing about this?
Since January 2012 the staffing levels at the DGH ED have slowly improved. In the spring of 2012, various initiatives to focus on improving wait times were implemented: 1) A nurse liaison role was implemented which provides a second assessment point for patients in the waiting room. This nurse begins to complete blood work and ECGs for patients ensuring test results are available when the patient is seen by the physician. 2) An Offload Team staffed by a nurse and paramedic has been implemented to offload ambulances and allow them to get back into the community. The Offload Team begins care for patients and there are times when more acutely ill patients are seen by the physician in this area before beds are available. 3) In October of 2013, a new process for transferring admitted patients to inpatient beds was implemented which should significantly decrease the time it takes for patients to leave the department when inpatient beds are assigned. 4) While this indicator shows average wait time for CTAS 3 patients, there has been a significant reduction in wait times for CTAS 4 & 5 patients by changing processes in the fast track area where lower acuity patients are seen faster, thus reducing door-to-physician time & their total ED length of stay.

The Flow Committee continues to look at flow within the department and make changes to how beds are filled and how patients no longer requiring beds can receive follow-up care in alternative locations, thus freeing beds up for those in need.

The following changes have been implemented at the HI ED:
- Continuous process improvements in the use of Pod 1
- Physician role and schedule alterations based on flow patterns
- Expansion of RAU hours to include weekend access

[Last updated November 2013]
1.12 Transmission Rates – MRSA

What is being measured?
MRSA transmissions are those cases that are acquired by patients while admitted to a Capital Health facility over a defined period of time.

Why is it important?
MRSA is one of the most significant antibiotic-resistant organisms that can cause healthcare-associated infections. If an infection occurs, antibiotic treatment choices are limited and the infection may be more difficult to treat.

In the health care setting, the primary ways in which MRSA is transmitted are the unwashed hands of caregivers, breaches in isolation precautions, and patient contact with contaminated and improperly cleaned communal equipment. MRSA is not airborne. MRSA does not cause one specific type of infection, but it may cause a variety of infections such as pneumonia, surgical wound infection, and urinary tract infection.

Careful hand hygiene before and after contact with the positive patient or their environment is one of the most important control measures for health care providers in preventing MRSA transmission.

How are we doing?
In 2011, according to the Canadian Nosocomial Infection Surveillance Program (CNISP) the national incidence rate was 12.44 per 10,000 patient days. The transmission rates at Capital Health have been far below this national rate.

What are we doing about this?
The following prevention and control measures are in place at Capital Health:
- All patients with MRSA are provided with a single room with dedicated toileting facilities. If a private room is not available, patients are co-horted, based on risk assessment with Infection Control.
- Staff and visitors are to wear a gown & gloves (no mask) when providing care or are in close contact with the patient/patient environment. Discard before leaving the room.
- Dedicate patient equipment (if this is not possible, clean and disinfect shared equipment after patient use). Thoroughly clean & disinfect all touch surfaces and equipment within the patient environment.
- Inform receiving departments/caregivers that Contact Precautions are required. Ensure that Transfer and Discharge Swabs are completed as per policy.
- Housekeepers spend extra time cleaning the environment after patients are discharged.
- Targeted approach to promote good Hand Hygiene.

[Text last updated Sept 2013]
1.13 Incidence Rate – VRE

What is being measured?
This indicator measures the rate of newly identified cases of VRE among patients admitted to a Capital Health facility over a defined period of time.

Why is it important?
VRE can cause a variety of infections, most commonly surgical site infection and urinary tract infections. VRE is, however, one of the most significant antibiotic-resistant organisms. So if an infection occurs, antibiotic treatment choices are limited and the infection can be more difficult to treat.

VRE is spread in health care settings primarily by the hands of health care workers, from breaches in isolation precautions, and from contact with contaminated equipment, or other surfaces. It is not airborne. Careful hand hygiene before and after contact with the infected patient or their environment is the most important control measure in preventing transmission.

How are we doing?
According to the Canadian Nosocomial Infection Surveillance Program (CNISP), the most recent national rate was 8.6 per 10,000 patient days (2012). The rates at Capital Health have been consistently below this national rate.

What are we doing about this?
The following prevention and control measures are in place at Capital Health:

- All patients with VRE are provided with a single room with dedicated toileting facilities. If a private room is not available, patients are co-horted, based on risk assessment with Infection Control.
- Staff and visitors are to wear a gown & gloves (no mask) when providing care or are in close contact with the patient/patient environment. Discard before leaving the room.
- Dedicate patient equipment (if this is not possible, clean and disinfect shared equipment after patient use). Thoroughly clean & disinfect all touch surfaces and equipment within the patient environment.
- Inform receiving departments/caregivers that Contact Precautions are required. Ensure that Transfer and Discharge Swabs are completed as per policy.
- Housekeepers spend extra time cleaning the environment and follow stringent protocols. VRE is tenacious and it is killed by regular hospital disinfectants but is hardy so we have to scrub to destroy it with enhanced cleaning protocols.

[Text last updated Sept 2013]
1.14 Infection Rate – C. difficile

**What is being measured?**
This indicator measures the incidence (number of new infections over a defined period of time) of *C. difficile* among hospitalized patients in Capital Health.

**Why is it important?**
*C. difficile* is a type of bacteria that causes diarrhea. It is the most common cause of infectious diarrhea in hospitalized patients. It is also one of the most common infections in hospitals and long-term care facilities. The use of antibiotics increases the chances of developing *C. difficile* diarrhea.

*C. difficile* infections can range from uncomplicated diarrhea to severe illness that requires prolonged treatment with antibiotics and sometimes surgery. In rare situations, a *C. difficile* infection can result in death.

**How are we doing?**
The 2012 national rate reported by the Canadian Nosocomial Infection Surveillance Program (CNISP) was 6.0 per 10,000 patient days. The rate at Capital Health has been consistently below this national rate. See the graph below.

**What are we doing about this?**
The following interventions have been instituted to prevent and manage *C. difficile* infections:
- Infection Control Practitioners review all new CDI cases to ensure appropriate precautions & interventions are in place & treatment is being considered when required.
- Antimicrobial handbook developed by pharmacy to optimize the appropriate use of antibiotics
- Environmental & housekeeping auditing with feedback
- Room cleaning checklist
- Enhanced Infection Control Measures outlined in new policy and procedure (based on national guidelines) to prevent transmission of C Difficile.
- Infection Control recommendations for design of future infrastructure include decentralized bedpan waste disposal, dedicated hand hygiene sinks, and single rooms
- Improved technology and modified cleaning procedures

[Text last updated Sept 2013]
1.15 Hand Hygiene Compliance

What is being measured?
Measuring adherence and providing feedback with accepted hand hygiene practices is an important quality improvement tool. The Accreditation Canada Qmentum Program now includes hand hygiene audits as one of the required organizational practices within the Infection Prevention and Control Standards. As a part of Accreditation, Capital Health is required to audit compliance with hand hygiene practices, share these results, and use the results to make improvements to current practices. The audit (and compliance) is based on the Four Moments for Hand Hygiene, the times at which hand hygiene should occur:

1. Before initial patient/patient environment contact
2. Before aseptic procedure
3. After body fluid exposure risk
4. After patient/patient environment contact

Why is it important?
Promoting hand hygiene is considered the cornerstone of infection prevention and control programs and of preventing healthcare-associated infections. The World Health Organization has suggested improvements in hand hygiene compliance can prevent 50% of hospital-associated infections, making it the single most important practice in reducing the rate of such infections. As caregivers move from patient to patient and room to room caring for people, their hands pick up microorganisms which can cause infections. Hand hygiene works by interrupting this transmission of microorganisms.

How are we doing?
For Jan–Mar 2014, the overall rate was 74%. This is the highest overall rate yet, but still short of the target of 80%. The “before” rate was 65% (under target) and the “after” rate was 81% (exceeding target). Greater detail is shown in the graph below.

What are we doing about this?
A targeted focus on Hand Hygiene practices will continue. Ongoing efforts include advancing staff and physician training across Capital Health. Patients are being educated through pamphlets and signage and are encouraged to wash hands when visiting the organization. A multi-modal campaign is ongoing and includes:

- Launch of new LMS (SHN) training module
- 2012/13 Hand Hygiene campaign (poster, screen saver, etc.)
- Targeted intervention for work groups
- Stop and Clean your hands day!
- Placement of alcohol-based hand rub product available at point of care
- Continued use of the automated hand hygiene audit tool
- “One stop shop” Internet site: educational supports through videos, guides, and additional information on the IPAC intranet site
- Facilitated access to compliance reports and enhanced the data available for front line leaders
- Just-in-time feedback to front line staff
- Patient Education pamphlet: Hand Hygiene
- Patient & Family Engagement Pilot Project (implementation late 2013/early 2014)

As well, Audits are done monthly in Heart Health and the results are posted for all staff to view. In Ambulatory Care at the Halifax Infirmary, requests have been made to Infection Control for completion of hand hygiene audits, but the audits have not yet been possible due to limited resources. Some Ambulatory Care staff members have been trained to perform audits, but these are not done regularly because of competing work commitments.

Several inpatient areas have worked with infection control to develop information sheets that are now being used on the units to advise both patients, families, and staff about the importance of hand washing.

[Text last updated Sept 2013]
1.16 Hospital Standardized Mortality Ratio

What is being measured?
Hospital standardized mortality ratio (HSMR) is the ratio of actual deaths to expected deaths, multiplied by 100. This indicator is calculated by the Canadian Institute for Health Information (CIHI).

The HSMR compares the actual number of deaths in a hospital with the average Canadian experience, after adjusting for several factors that may affect in-hospital mortality rates, such as differences in age, sex, length of stay, admission category (planned vs. urgent/emergent), diagnosis group, selected comorbidities, and transfer from another acute care institution. CIHI calculates the ratios using data submitted from hospitals across the country. It only includes the 72 diagnosis groups that account for the top 80% of in-hospital deaths in Canada.

Fiscal year 2009/10 is the baseline year in which the national average has been designated as 100. As such, an HSMR greater than 100 suggests the local mortality rate is higher than the national experience in 2009/10 (unfavourable). Conversely, HSMR scores less than 100 suggest the local mortality rate is lower than the national experience in 2009/10 (favourable).

Why is it important?
HSMR is a high-level measure that can be influenced by a wide variety of factors, some of which are beyond the control of an individual hospital. Nevertheless, it provides an important means for a hospital or health region to compare their patient outcomes over time and in this way provides a starting point for identifying potential areas for improving the quality of care.

How are we doing?
The graph below shows the HSMR for CDHA for fiscal years 2007/08 to 2011/14 Q1–Q3. In fiscal years 2007/08 to 2009/10, CDHA had HSMRs that were statistically significantly worse than the 2009/10 national average (i.e. greater than 100), but had HSMRs that were on par with the 2009/10 national average for fiscal years 2010/11 and 2011/12. In 2012/13 CDHA’s HSMR score returned to a level that was statistically significantly higher (worse) than the 2009/10 national average. For Q1–Q3 of 2013/14, CDHA’s HSMR score returned to being on par with the national average.

What are we doing about this?
Capital Health has developed a process to review HSMR data results in further detail. Based on findings from this initial review, further assessment is done with co-leads and quality teams to better understand circumstances and practice related issues which may affect the cases contributing to the HSMR. Findings from the review inform the development of quality improvement initiatives. [Text last updated April 2013]
1.17 Patient Experience Survey

What is being measured?
Throughout the year, patients in inpatient, ambulatory and rehabilitation services are randomly sampled to partake in the patient experience survey and the results are reported annually. This indicator shows the proportion of “agree” or “disagree” responses in a particular dimension or section of the survey. The data presented here summarize the Inpatient and Ambulatory Patient Experience Surveys. Mental Health and Cancer Care patients are not included; they are surveyed separately using a different tool.

Why is it important?
The survey results can be used to identify strengths and opportunities for quality improvement initiatives and accreditation requirements. The positive patient experience target has been set at 90%.

How are we doing?
In 2012/13, Our positive response target of 90% was exceeded in five out of eight patient experience dimensions. At an organizational-level, patients rated Overall Assessment of Care Received, as well as Care Received from Health Professionals at 94% satisfaction. Respect for Rights was rated at 93% positive response; Accessibility of Services, and Care Received in Emergency Department were rated at 91% and 90% respectfully.

Queries related to Opportunity to Ask Questions Regarding Condition (96%) and Trust and Confidence in Healthcare Professionals (95%) both had high positive response rates. This fiscal year marked significant positive feedback for both the Cultural Values Taken into Account, and Diversity Status Respected and Valued by Hospital Staff dimensions (97% and 96% positive response respectively).

What are we doing about this?
Organizationally, we work under the belief that a focus on quality and patient safety is integral to becoming a world-leading haven for people-centred health, healing and learning. Quality is achieved by ensuring that the services and supports we provide have a positive effect on the health and safety of our citizens. Every three years we go through the process of Accreditation as we look for more ways to improve the quality and safety of our health care services. We have implemented a Patients First Safety strategy, which states that getting involved in patients safety at Capital Health is everyone’s responsibility. We have also created and implemented tools to support teams in their quality improvement journey, such as Quality and Patient Scorecards.

[Last Updated September 2013]
1.18 Patient Safety Culture

What is being measured?
Patient safety culture measures and assesses staff awareness about patient safety. Patient safety culture exists when people within a health care organization are compelled to take action when faced with safety challenges, and consistently work towards changes that improve patient safety. Accreditation Canada’s Patient Safety Culture Survey was first administered to staff and physicians in 2006, and repeated in 2010 and 2012. It consists of 40+ questions about the culture of patient safety within our organization. Of particular interest within this survey is the question: “Please give the organization an overall grade on patient safety” with five possible responses: Excellent, Very Good, Acceptable, Poor, or Failing.

Why is it important?
Culture is widely recognized and accepted as an essential element in changing both behaviour and expectations in order to improve patient safety in health care organizations. This measure is important as it helps to identify strengths and areas for patient safety culture improvement in our organization. It also helps examine trends in patient safety culture change over time. Staff perceptions of the ‘overall patient safety’ measure provides insight into the degree to which patient safety culture exists, and further evaluates the cultural impact of patient safety initiatives and interventions.

How are we doing?
In all years, the majority of survey responses fell under the “Very Good” and “Acceptable” response categories. Over time, there has been a trend of a decreasing proportion of “Acceptable”, “Poor”, and “Failing” responses, and an increasing proportion of “Excellent” and “Very Good” responses.

What are we doing about this?
The focus on developing a strong culture of patient safety continues. Ongoing efforts include multiple educational opportunities for staff and physicians related to patient safety. The multi-pronged approach also includes:

- An integrated Quality and Patient Safety Plan for the entire organization, which includes a campaign to raise awareness related to just culture.
- Bi-weekly Leadership Safety Rounds in which staff members on individual patient care areas address patient safety issues with representatives from multiple areas within the organization, including a representative from the executive team.
- Patient Safety Culture discussion cards and an accompanying resource manual have been developed for use at the service level and has been presented to quality team leaders and managers across the organization.
- Fifteen patient safety modules in the LMS which are applicable to physicians and employees throughout the organization.
- Quality rounds focused on patient safety culture.
- Patient Safety Week and Quality Week events which showcase the leadership and team specific actions in various service areas across the organization.

[Last updated August 2013]
1.19 Completion of Patient Safety Training

**What is being measured?**
One of Accreditation Canada’s Required Organizational Practices is the delivery of client safety training and education at least annually to employees. A required organizational practice (ROP) is an essential practice organizations must have in place to enhance patient/client safety and minimize risk. To fulfill this ROP, CDHA requires all employees and volunteers to annually complete at least one patient safety course.

**Why is it important?**
Everyone that works at Capital Health has a role in patient safety. Therefore, completion of annual patient safety training is a vital component of patient safety and quality improvement. Patient safety training has been shown to enhance patient care and minimize potential safety risks within the organization.

**How are we doing?**
The graph below shows the percentage of CDHA employees, medical staff, learners, and volunteers who completed at least one patient safety course. The annual target is to reach 100%. For the complete 2013/14 fiscal year, 40% have completed a patient safety training course.

**What are we doing about this?**
Annual education on patient safety is made available to the organization’s leaders, staff, service providers, and volunteers, and CH identifies specific patient safety focus areas such as safe medication use, using the reporting system for adverse events, human factors training, techniques for effective communication, equipment and facility sterilization, hand washing and hand hygiene, and infection prevention and control. Most employees can fulfill this requirement by completing one of the six online patient safety courses using the Learning Management System (LMS). Others, such as volunteers, are provided the training as part of orientation packages and presentations.

[Text last updated December 2012, except reference to graph]
Additional Transforming Person-Centred Health Care Experience Indicators

1.20 Length of Stay – Number of Conservable Days

What is being measured?
This indicator is the number of conservable days which is the average length of stay (ALOS) minus the expected length of stay (ELOS) multiplied by the total number of cases.

Why is it Important?
Conservable Days is a measure of the days that patients remain in hospital beyond the expected ALOS expected for their diagnosis. Tracking of this information provides an indication of the hospital's success in discharging patients against an established benchmark.

How are we doing?
Conservable days for typical cases are shown in the graph below. The target is 6,188 or fewer.

For the full 2013/14 fiscal year, conservable days totaled 6,223. This is an improvement over the past three years but just short of the target (unfavourable).

What are we doing about this?
Capital Health has implemented a number of improvement initiatives:
- A Bed Utilization Management Process (BUMP) has been implemented in all acute medical/surgical care units, Intermediate Care Units and Critical Care Units across the district. Information from this tool is used daily to focus efforts on patient flow, and discharge planning.
- Home First strategies and community based supports have been implemented to promote home and community based care as an option to hospitalization.
- Patient Flow Management on a 24/7 basis has been implemented to leverage all opportunities to improve flow across systems at QEII.
- Physician models have been realigned especially in Internal Medicine and Community Medicine to address specific areas of patient flow.

At Hants, white boards and bullet rounds have been implemented to improve discharge planning and improve occupancy and length of stay. With this, staff feels there has been an increase in earlier discharge.

[Last updated October 2013]
1.21 Occupancy Rates

What is being measured?
Occupancy rate is patient days (census days) divided by available hospital days, multiplied by 100. Total occupancy rates for this indicator do not include long term care/transitional care. This is because the occupancy rate target for long term care is 99% which differs from the target occupancy rates. Occupancy rates are also calculated for individual units and services.

Why is it important?
Occupancy rate is used to show the actual utilization of the hospital for a given period of time and has a direct affect on inpatient and emergency department flow.

How are we doing?
Capital Health’s target is to decrease the occupancy rate to 90%.

The graphs below show the yearly occupancy rates for services at the QEII and the Dartmouth General. For April 2013 to March of 2014, the following services were below the target of 90% (favorable): QEII Surgical, QEII ICU, and DGH ICU/CCU. All other services were above the target (unfavourable).

The overall rate for the QEII was below the target (favourable) while the overall rate at the Dartmouth General was above target for this period.

In April 2014, the first month of the 2014/15 fiscal year, the same services and facilities were above and below the target.

It should be noted the occupancy rates for QEII psychiatry from 2007 to 2010 are an underestimate because they had four beds that were listed as “open” in the STAR system, but weren’t actually available for use. An estimated correction would put all the psychiatry occupancy rates higher than the target for these time periods. The bed counts were corrected in STAR in January 2011 and so occupancy rates for psychiatry after this date reflect the true situation on the service.
DGH Occupancy Rates

Graph Update Frequency: Monthly
Graphs Last Updated: June 2014
Next Graph Update Expected: July 2014
1.22 Emergency Department – Left Without Being Seen

What is being measured?
This indicator is the number of patients who left the emergency department without being seen by a physician divided by the total number of emergency registrations. The count of patients who left without being seen does not include those patients who were seen by a nurse in the emergency department instead of being seen by a physician.

Why is it important?
Each month, hundreds of patients who arrive at emergency departments across Capital Health subsequently leave without being seen by a physician. While many of these patients may have symptoms or conditions that can be safely dealt with by alternative means, it is a concern that someone with a significant problem may leave and the consequences could be serious. At the Dartmouth General, a discharge planning nurse keeps a record of patients who leave without being seen and calls patients to provide follow up suggestions.

How are we doing?
The graph below shows the percentage of patients who left the emergency department without being seen (all triage acuity levels combined). A breakdown by emergency department site is shown. The target is to keep walkouts below 2% all across Capital Health. All sites except Hants are over the 2% target.

For additional emergency-department indicators, click here to go to the CDHA Emergency Departments Quarterly Performance Reports web page.

What are we doing about this?
The following initiatives have been implemented at Hants:
- Nurse-initiated protocols allow nurses to start patient care prior to being seen by a physician. One example is for the treatment of sepsis patients.
- Waiting room rounds to improve communication between triage area, the department, and waiting room patients in an effort to keep patients who are waiting better informed and to allow them to make more informed decisions, increase patient satisfaction and decrease rates of patients leaving without being seen.

[last updated April 2014]
What is being measured?
This indicator is the number of patients placed and number of patients awaiting placement in long term care (LTC) facilities. It includes patients at all Capital Health sites. These graphs represent LTC patients from all Capital Health facilities. Both acute care and mental health LTC patients are included.

Why is it important?
At any one time, patients who require care—but not acute care—may occupy a substantial number of beds in hospital facilities. Often they cannot be discharged from hospital until alternate services, such as residential care, are available. For this reason, a measure of the number of patients waiting to be placed is a measure of appropriate hospital utilization and the ability to respond to client needs.

Once a patient’s application is approved, he or she remains on a waitlist until a bed in the appropriate type of facility becomes available, unless their medical status changes. The application process involves a standardized provincial application, consisting of both health and financial assessments.

How are we doing?
The target is to have fewer than 75 patients waiting to be placed into LTC (excluding Mental Health). The graphs below show the number of Capital Health patients placed and waiting to be placed into LTC facilities. In March 2014, the total number of patients at all Capital Health facilities (excluding Mental Health) waiting to be placed was 77. This is the lowest the count has been in several years but still slightly above the target of 75.

Over the past year there has been dramatic improvement at the QEII in the number of patients waiting to be placed into LTC. In November 2012, there were over 80 patients waiting. Most recently, in March 2014, there were only 23.

In order to meet the LTC needs of their patient population, the Mental Health Program works with the Department of Health and Wellness (DoHW) for traditional LTC (nursing home) placements, as well as with the Department of Community Services (DCS) for non-traditional LTC placements such as Adult Residential and Small Options. DCS operates under a different set of rules & guidelines than DoHW and in a more risk averse and cautious manner. This results in Mental Health experiencing a much higher percentage of beds being occupied by patients awaiting placement, by comparison.

In Capital Health, as of April 30th, 2014, there were 750 people in the community waiting to be placed in LTC facilities. The number of people waiting in the community last year (May 1st, 2013) was 777 (source: Department of Health and Wellness SEAscape database).

What are we doing about this?
The Home First Philosophy was rolled out at Hants a month ago. All staff and physicians received education and a new agency was contracted in the area for home care for those leaving hospital. Early success was seen when one hospitalized ALC patient returned home with additional supports. The team culture is changing to one supporting clients being in their homes with supports instead of requiring hospitalization. Historically, Hants has had 20 or more ALC patients awaiting placement in hospital.

At the Halifax Infirmary site, units 7.3 and 8.1 have been working with Continuing Care on Home First as well as nursing home placement and have seen a decrease in the number of patients waiting for placement.

[Last updated April 2014]
1.24 Strengthen Community-Based Care for Chronic Disease

**Strategy:** Transforming Person-Centred Health Care Experience

**Goal:** Significant increase over baseline of chronic disease management in the community where appropriate

**Measure:** 5% reduction in the number of return outpatient visits annually at selected clinics in relation to hypertension, heart disease, COPD, and diabetes.

**What is being measured?**

An increase of chronic disease management occurring in the community will translate into, and will best be measured by, a reduction in the number of return clinic visits related to key chronic diseases.

The focus will be on the most common chronic diseases—hypertension, heart disease, COPD, and diabetes.

The target is to achieve a 5% reduction, or 425 fewer return visits, by 2015/16. This will indicate success in diverting patients from the hospital into a community setting. The goal is to avoid bringing stable patients into the hospital when they can be better supported in the community.

We have been projecting a 5 to 10% increase demand at Capital Health clinics, so the 5% net reduction from the baseline calls for an effective decrease (from projections) of 10 to 15%. Given the aging population and the rising rates of chronic disease, this is felt to be a challenging target.

**Why is it important?**

The aging population and growth in chronic disease means that community-based models are crucial. There is a need to move out to the community, upstream, and care for patients with chronic diseases as a single person—in their entirety—in a way that is convenient and empowering.

**How are we doing?**

As a baseline, total return visits to the clinics directly related to hypertension, heart disease, COPD, and diabetes in 2011/12 was 8,500.

**What are we doing about this?**

Barbara Hall, VP Person-Centred Health and David Anderson, chief and head of the Department of Medicine, have convened an action team to tackle this challenging measure. The team will develop an action plan and timeline by June 30, 2013. Three major actions for achievement of this 2015/16 goal are:

1. Chronic disease data source identification, evaluation, and implementation of CDM Health System Model
2. Development and implementation of engagement Strategy: Citizens; District Specialists and Family Physicians
3. Leverage ongoing District Chronic Disease Management Work

The expansion of the Diabetes Management Center to a Chronic Disease Management Center, as part of the West Hants Community Primary Health Care Model, supports a commitment to this goal.

[Last updated: April 2014]
1.25 Improve Quality of Care in Transitions

**Strategy:** Transforming Person-Centred Health Care Experience

**Goal:** Care teams will improve achievement in meeting established standards in the quality of care at key transition points substantially over 2012 baseline levels.

**Measure:** 50 per cent compliance in documenting patient instructions on the discharge summary.

**What is being measured?**
We audited 1000 discharge summary reports to determine compliance on five mandatory key quality elements required to be included in the report: final diagnosis, outcome of care, arrangements for follow-up, medications and patient instructions/education.

Our results for the first four elements are considerably higher than the last. Compliance on including patient instructions in the discharge summary report is low at just 22.5 per cent. It is also an area highlighted in our patient experience survey results as one that needs focus.

We want to more than double this result in three years, bringing it up to a 50 per cent compliance rate. This will require a substantial change in practice and culture. We’re already making some progress and undertaking a lot of work in this area. For example, we’re making these items required computer entry fields when completing a discharge.

**Why is it important?**
Transitions are a major challenge for health care systems everywhere, and Capital Health is no exception. Everyone wants their loved one to receive the best possible care, including seamless, complete “hand-offs” between departments and care facilities.

Transitions are a “big dot” indicator of the performance of the system in terms of patient safety and quality – many experts across the country believe it is one of the most important, and it is covered in an Accreditation Required Organizational Practice.

**How are we doing?**
Current baseline results: A baseline audit of 1000 discharge summary reports from April to September 2012, by site and service, was performed. Overall results for compliance on five mandatory key quality elements required to be included in the discharge summary reports for the QEII and DGH were 22.5%

**What are we doing about this?**
Catherine Gaulton, Vice-President, Performance Excellence & General Counsel, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Safe patient information transfer
2. E-Discharge tool implementation
3. Improve transitions of care for individuals with chronic conditions from the child-based to adult-based systems.

[last updated August 2013]
1.26 Build a Culture of Customer Service

**Strategy:** Transforming Person-Centred Health Care Experience

**Goal:** Patients, families and communities report customer service interactions with Capital Health employees and physicians meet or exceed their expectations.

**Measure:** 20 point increase in the percentage of patients responding most favourably on customer service related survey questions.

**What is being measured?**
We currently collect data on patients’ assessment of customer service through our patient experience survey. We started with an item on the survey that most closely relates to customer service—whether patients feel they have been treated with courtesy and respect. We then did a correlation analysis to find other items that most closely link to it, and ended up with a cluster of customer service related items on which we already collect data.

We have chosen to focus on patient responses at the top of the positive scale, in other words “strongly agree” or “4 out of 4.” Research in other industries has shown that the difference in customer loyalty between those responding at the top of the customer service scale and those responding one step down can be as much as six times difference.

The issues and results are quite different between the inpatient setting and ambulatory care. For example, in ambulatory care, key issues are the availability of parking and ease of registration. The inpatient setting is far more complex, involving everything from cleanliness to whether the care provider voices complaints about working conditions. Overall, our goal is to ensure everyone experiences better customer service at Capital Health. Our target of 20% is essentially a proxy for that. It’s a challenging and achievable goal, which will require focused attention on the various issues.

**Why is it important?**
This goal really speaks to our commitment to the “relentless pursuit of excellence in care and service.” Excellent customer service is founded on being treated with dignity and respect.

**How are we doing?**
Current baseline results: The Patient Experience Survey is conducted three times a year. Inpatients and Ambulatory Care patients are surveyed separately. In 2012, we received 4,576 responses. On inpatient surveys, 31% of respondents responded most favourably and on Ambulatory Care surveys, 66% of respondents answered most favourably.

**What are we doing about this?**
Kathy MacNeil, Vice-President, People, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Customer service training for employees & physicians
2. Care experience redesign from a quality and patient safety perspective
3. Infrastructure plan for sustainability

Both Pharmacy and Outpatient Nephrology signed up to be the pilot areas for the customer service training. All formal leaders from both areas have attended the training sessions, including Dr. Ken West. The remainder is in the process of taking the course. Already in outpatient nephrology, the staff members have done some targeted work with some patients in being deliberate in actively involving them in developing goals and plan of care.

All staff members at the Dartmouth General are moving forward with customer service training.

[Last updated April 2014]
2 Citizen and Stakeholder Engagement and Accountability

2.1 Partner with the Public so Individuals and Communities can Play a Key Role in Managing Their Own Health

**Strategy:** Citizen and Stakeholder Engagement and Accountability

**Goal:** Significant increase in number of individuals reporting that Capital Health has supported them in playing a key role in managing their own health.

**Measure:** 10 point increase in percentage of residents who say they have received support in managing their own health.

What is being measured?

In 2013, we carried out a telephone survey of Capital District residents. The survey provided data for the “Managing own health” baseline and also the “Appropriateness of care” baseline.

We spent a lot of time considering how to get at what the public understands, rather than what health care providers understand.

We decided that the key question was “In the past 12 months have you received any support related to managing your own health?”

We’d like to see the percentage of respondents who say they have received support in managing their own health rise by 10 points. That would be a significant shift in our citizens’ experience of being supported in health and with illness.

Why is it important?

This is about empowering people to take ownership of their own health, including prevention of illness and maintenance of well-being. We can help by providing them with direct support, and by supporting others who provide support, such as providers and family members.

We need to educate those we serve about what care is available to them in their own community.

How are we doing?

Current baseline results: In 2013, Thinkwell Research conducted a field survey in which 52% of 655 respondents indicated they had received support related to managing their own health.

What are we doing about this?

Barbara Hall, Vice-President, Person-Centred Health and Gaynor Watson-Creed, Medical Officer of Health, have convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

- Explore the needs of family physicians for resources to support them in information/community access role
- Explore the use of social media & other tools as a way of engaging with residents to learn what being/feeling healthy means to individuals, sharing perspectives & stories. Utilize tools to enable online access to reliable, brief, clear messages & links to accurate resources
- Identify and promote/communication what is available in communities for a diverse community of individuals at different stages of life

[Last updated August 2013]
2.2 Involve Patients Directly in Their Care

**Strategy:** Citizen and Stakeholder Engagement and Accountability

**Goal:** Patients or their surrogates report that their involvement in decision-making related to their care met or exceeded their expectations.

**Measure:** 10 point increase in the percentage of patients responding positively to a survey question about being consulted in decision-making about their care.

**What is being measured?**
We currently collect data on patients’ assessment of their involvement in decision-making through our patient experience survey.

Our baseline results, including all positive responses, are just under 80% favourable. Our target is to increase this by 10 percentage points, to just under 90% favourable.

We’re expecting that one of the actions we’ll take to reach this target is to make greater use of shared decision-making tools in the clinical setting. This already occurs in Surgery.

**Why is it important?**
This goal is about culture shift. Patients need to know that we want them to be involved in key decisions related to their care. Staff need to understand we are encouraging patients to ask to be included in their own care.

Communications and customer service will be the key to success. Listening well to patients has been shown to improve care quality and patient perceptions of quality.

**How are we doing?**
Current baseline results: In the 2012 survey, 78% of respondents responded “agree” or “strongly agree” to the survey item: “Healthcare professionals consulted me or my family or caregiver in making decisions about my care.”

**What are we doing about this?**
Paula Bond, Vice-President, Person-Centred Health, Acute Care, and David Kirkpatrick, interim head/chief, Department of Surgery, have convened an action team to develop a plan. Three major actions for achievement of this 2016 goal are:

- Develop and implement care plans for all inpatients outlining immediate, medium and long-term goals with clear protocols related to care plan review for patients with LOS <3 days and >3 days
- Identify and adopt district-wide criteria for involving patients/families in their care and embed in operation clinical policies and practice to encourage and support patient/surrogate participation in health care decision-making across all service areas
- Enhance education and communication for patients (or their surrogates), families and clinical teams related to the patient’s responsibility as an active participant in health care decision-making.

To engage patients and families in their care and to create efficiencies at the Dartmouth General, white boards have been placed at patient bedsides and a patient booklet with goals of care have been developed. A discharge checklist and readmission risk assessment tools are also under development. The health passport is being updated for the surgical population.

[Last updated April 2014]
2.3 Lead Dialogue with the Public Addressing Appropriateness of Care

Strategy: Citizen and Stakeholder Engagement and Accountability
Goal: Improve public awareness of quality of life issues related to appropriateness of care.
Measure: 20 percentage point increase in the percentage of Capital District residents surveyed who report a high degree of familiarity with the concept of appropriateness of care.

What is being measured?
In 2013, we carried out a public opinion survey that included questions designed to establish a benchmark for the “managing own health” goal and the “appropriateness of care” goal. A total of 655 citizens responded.

Awareness of the concept of “appropriateness of care” is much more important than awareness of the healthcare jargon we use to label it. One in five of those surveyed responded that they are “very familiar” with the concept of appropriateness of care, once it was described to them.

As a challenging and achievable target, we want to double the percentage of residents who are “very familiar” with the concept of appropriate of care, anticipating that this will pull the whole curve of respondents upward.

Why is it important?
Appropriateness of care refers to care that is right for the individual being treated, taking into consideration their expectations and who they are as a whole person.

Conversations about appropriateness of care have been taking place behind closed doors for years. We need to educate people so we can have these conversations out in the open, and well in advance of the point of care, so we are enabling informed decision-making on issues related to quality of life.

How are we doing?
Current baseline results: In 2012, 22% of 655 respondents indicated they were “very familiar” with the concept of appropriateness of care.

What are we doing about this?
Chris Power, President & CEO, and Nick Delva, District Medical Advisory Committee Chair, have convened an action team to develop a plan. Three major actions for achievement of this 2016 goal are:

- Influence patient and provider conversations: strategy, supports and tools
- Action and advocacy on system issues related to providing appropriate care
- A comprehensive and integrated engagement and communication/marketing campaign to support appropriateness of care conversations

[last updated August 2013]
3 Transformational Leadership

3.1 Absenteeism

What is being measured?
This indicator is the average amount of employee paid ill time away from work per month. Employee ill time is an illness of the employee and covered under General illness, sick banks and short term illness. It is not time away for family illness or preventative appointment time. It includes paid sick time (NSNU employees), paid general illness (all other employees), short term illness, and grandfather illness long term disability at 100%.

Why is it important?
Employees who are not at work due to illness affect a team’s workload and patient care. Absenteeism results in managers having to pay employees overtime which results in high health care expenses as well as employee burnout, which can impact patient care.

How are we doing?
A graph of the average sick hours per eligible employee per month at CDHA is shown below. The target is to have 6.15 or fewer hours per month. For the complete 2013/14 fiscal year, the average monthly sick hours was above target at 6.82 (unfavourable). There was an improvement in April 2014 when the rate dipped to 6.48, but this is still over target.

The organization is currently experiencing a high rate of absenteeism. This is during a time in which there are hiring challenges for nursing positions throughout the organization. These challenges result in more staff having to work even more overtime.

What are we doing about this?
Employee Health has Rehabilitation Consultants working with employees who are off ill greater than five days of absence. People Services is working to fill vacancies and most recently completed a mass hiring of graduate nurses. While these nurses fill the FTE they are, still junior in experience and will require mentoring to build skills and knowledge. The impact of these staff on the units will be more evident in the coming years.

Healthy Workplace along with Wellness and Safety services have combined forces to provide educational programs for frontline managers to enable them to recognize signs of workplace fatigue attributed to stress. An October 2011 workshop on mental health at work was scheduled as education for senior leaders. In the fall of 2012, communications were sent to employees in the Patient Centred Care Portfolios thanking them for their attendance, while ensuring accountability around sick time usage.

People Services has also teamed up with Wellness and Safety to help deliver education opportunities to assist managers with the utilization of employment contracts around culpable sick time, improving accessibility by means of identification/promotion of services. Relevant quality operational indicators are being identified and will be used to determine the best services available to meet these goals. Measures have been put in place to make pre-hire OH screening mandatory prior to hiring to ensure the new hire is a fit for the position.

The Heart Health Program/Ambulatory Care at the Halifax Infirmary has 28 staff members on Attendance Management Program.

[Last updated April 2014].
3.2 Overtime

What is being measured?
This indicator is total hours worked overtime divided by the total hours worked, multiplied by 100.

Why is it important?
The amount of OT incurred by a unit and the organization at large is costly from a few points of view. There is a higher financial cost to the organization and the entire health care system, employee have a decreased work life balance and time to recharge from working, potential risks to patient care due to employee fatigue.

How are we doing?
The graph below shows the percentage of overtime worked at CDHA. In 2013/14, the percentage of overtime hours worked was 1.36%. This is better than the previous year and is better than the target of 1.89%. In April 2014, the rate remained better than target at 1.31%.

There was an increase challenge in hiring staff over this fiscal year leaving many positions vacant for longer periods and higher frequencies.

What are we doing about this?
There are many different overtime initiatives across the organization to help reduce the amount of time used. Some examples are:
- Manager scrutiny of budget reports
- Newly developed Nursing Resource Team, this will take a couple of years to fully establish positive impacts on overtime.
- Central Staffing Office at the QEII site
- Rollout of Kronos Staff scheduling system at the QEII site for the central staffing office.
- Review of Models of Care to ensure we have the right resources doing the right jobs at the right time.

[Last updated June 2013]
3.3 Employee Survey

**What is being measured?**
This indicator is the percentage of favorable, neutral, and unfavorable responses in various sections of the employee surveys conducted in 2009 and 2011.

**Why is it important?**
At Capital Health, we have made a promise to be a world-leading haven for people-centred health, healing, and learning. We can only achieve Our Promise if each of us experiences Capital Health as a rewarding, satisfying, and healthy place to work. That's why every two years, an employee survey is conducted. The survey allows the measurement of progress and the answers the following questions: How are we doing? Where could we be doing better? What will we celebrate?

**How are we doing?**
The graph below shows a selection of the results of the 2009 and 2011 Capital Health Employee Surveys. The selection of results presented in this report are meant to highlight a sample of areas to be celebrated and areas where improvements could be made.

From the graph it can be seen that both pride and trust in peers had very high percentages of favorable responses in both 2009 and 2011. Spiritual wellness was not part of the 2009 survey, but had a very high percentage of favorable responses in 2011. Some of the areas for improvement include psychological safety, involvement in decision making, and trust in management.

**What are we doing about this?**
Teams throughout Capital Health will receive team reports in June 2011, have conversations, and implement action on ways to improve their workplace. This process is the most meaningful for staff as each unit or department is unique and will have unique interests and ideas that the organizational response to survey results may not address. The 2011 survey team will make one to two recommendations based on analysis of the organizational survey results—looking at statistical and practical significance of the results and the relationships among the survey measures. The team will look for leverage opportunities based on this analysis and the prospect of alignment with existing or planned strategies within Capital Health and our larger community.

![Selected Results From the 2009 & 2011 Employee Surveys](image)

*Frequency Tracked: Approx. every two years  
Last Updated: June 2011  
Next Update Expected: 2014*
**3.4 Employee Survey – Accreditation Canada Worklife Pulse**

**What is being measured?**
The Worklife Pulse Tool helps organizations identify strengths and opportunities for improvement in their work environments, plan appropriate interventions to improve the quality of worklife, and develop a clearer understanding of how quality of worklife influences the capacity of an organization to meet its strategic goals. The survey takes the “pulse” of quality of worklife, providing a quick and high-level snapshot. The survey is intended to complement the organization’s full-scale employee survey.

**Why is it important?**
It is widely recognized that the health care environment is one of the most challenging within which to work due to the physical and emotional nature of work, the high risk of work-related injury, heavy workloads and work schedules, and the high rate of change in the work environment. For this reason, the concept of quality of worklife is central to the Accreditation Canada Qmentum program. Worklife is one of the quality dimensions of Qmentum, with content throughout the core standards, Required Organizational Practices (ROPs), and the Worklife Pulse Tool.

**How are we doing?**
Employee ratings of ‘job satisfaction’ and ‘clarity about expectations’ remained high for 2012. However, there were slight increases in the number of ‘unfavourable’ responses in almost all dimensions – see graph below.

**What are we doing about it?**
Analysis of the 2012 results led to a number of actions at the organizational level. Leadership intentionally engaged employees in the process of renewing the strategic plan including identifying organizational priorities for 2013-2016. In order to provide clarity and more succinct direction, the numbers of areas of focus in the new strategic plan were narrowed from 35 to 14.

Results of analysis also showed that engagement of employees for sustainable change required action at the interdisciplinary team level. In order to support improved employee satisfaction at the “front-line” of care and service provision, a toolkit with individualized data was created, and facilitation was provided to teams for action planning based on these more specific results.

As of June 1, all Quality and Patient Safety Teams had identified two- to three-item key areas for improvement based on their individual Worklife Pulse results.

[Last updated September 2013]
3.5 Physician Survey

What is being measured?
This section presents the percentage of favorable, neutral, and unfavorable responses in selected sections of the physician survey. The 2011 Capital Health Physician Survey was created by Physician Services in consultation with several department chiefs, and the presidents of both DMSA and DMAC. In January and February 2011, physicians from all medical staff categories (active, resident, fellow, associate, consulting, courtesy, clinical associate, clinical trainee, and locum tenens) were invited to complete a survey. The survey data were collected through ClearPicture, an independent survey firm. The response rate was 54%.

Why is it important?
The information uncovered through this survey process will assist Capital Health in further developing and strengthening relationships with physicians for the sake of improved patient centered care.

How are we doing?
The graph below shows the results for six selected sections of the physician survey. Of the six shown, trust in colleagues and respect had the highest percentages of favorable responses, while trust in Capital Health management and engagement with Capital Health had the lowest percentages of favorable responses. Transformational leadership and co-leadership fell in between.

What are we doing about this?
Initiatives such as Co-Leadership have been established to increase physician involvement in leadership at Capital Health. Co-Leadership work focuses on improving relationships for the sake of improved performance. Novel development work was recently presented at the Canadian Association for Health Services and Policy Research Annual Conference. The Fully at the Table program is still offered and is the focus of a national research investigation exploring ways to advance leadership for the sake of improving health care.

Selected Results from the 2011 Capital Health Physician Survey

- Trust Colleagues: 87% favorable, 9% unfavorable, 4% neutral
- Respect: 69% favorable, 20% unfavorable, 11% neutral
- Evidence of Transformational Leadership: 59% favorable, 24% unfavorable, 17% neutral
- Co-Leadership: 51% favorable, 23% unfavorable, 26% neutral
- Trust Capital Health Management: 37% favorable, 34% unfavorable, 29% neutral
- Engagement with Capital Health: 35% favorable, 37% unfavorable, 28% neutral

Frequency Tracked: Every two years
Last Updated: June 2011
Next Update Expected: 2014
3.6 Improve Leadership Capacity at all Levels

Strategy: Transformational Leadership

Goal: Employees and physicians working at Capital Health will meet or exceed expectations of leadership in their work as defined by the Capital Health leadership capabilities.

Measure: 20 point increase in the percentage of employees and physicians responding most positively on survey scales related to leadership.

What is being measured?
In 2012, we conducted a survey of employees and physicians on three dimensions of leadership:

1. Self-reported knowledge of the expectations of each employee/physician to be leaders
2. Assessment by employees and physicians of the leadership of their formal leaders
3. Self-reported assessment of employee’s and physician’s own leadership.

More than 1000 staff and 50 physicians responded. Our baselines reflect the top of the range – percentages of responses at 4.5 or higher out of 5.0. Focusing on those 4.5 or 5 responses, we target is to achieve a 20 point increase on all three dimensions.

Why is it important?
We are putting our patients at the centre of all that we do. At the same time, we deliberately use the word “people-centred” in our mission statement. We must continue to invest in those who serve, helping everyone step up in their job to make things better, and providing an environment where employees and physicians embrace and deliver on their responsibilities to our patients.

How are we doing?
Current baseline results: In the 2012 leadership survey, the following percentages of respondents indicated 4.5 or higher out of 5 in each of the three dimensions:

- Clear Expectations: 13%
- Transformational Leadership (formal leaders only): 21%
- Leading in Own Work: 25%

There were no statistically significant differences between physicians and employees.

What are we doing about this?
Kathy McNeil, Vice President, People, and Steven Soroka, Vice-President, Medicine, have convened an action team to develop an action plan. Two major actions for achievement of the 2016 goal are:

- Set clear expectations; provide support and accountabilities for demonstrating the CH leadership capabilities with behaviours and actions on the job
- Demonstrate leadership capabilities by developing an excellent customer service culture

[Last updated: August 2013]
3.7 Strengthen Accountability of Employees and Physicians.

**Strategy:** Transformational Leadership  
**Goal:** Staff, management and physicians at all levels report being held accountable for their performance.  
**Measure:** 20 point increase in the percentage of staff, management and physicians responding most positively on survey items measuring self reported accountability.

**What is being measured?**
As with the leadership measure, we recently conducted a survey of employees and physicians on accountability. The survey included a cluster of items that correlate to form a scale. We asked respondents if they were clear on what is expected of them in their role, if they had received feedback on their work in the past 12 months, and if they feel they are held accountable in their work.

Our baseline reflects the top of the range – percentages of responses at 4.5 or higher out of 5.0 on average for the scale. Again, we are looking to shift the whole curve up – our indicator is at the top end, but we are looking to address this issue across the board.

Thirty-five per cent of respondents answered “most positively” on the survey. Our target is to achieve a 20 point increase on this result.

**Why is it important?**
Transformation requires leadership, and accountability is a big part of that. What we heard loud and clear through our strategic engagement process was a call, from staff and the public, for more accountability for action.

At Capital Health, we are building a culture of accountability. Over the past three years we have sown the seeds of leadership through the My Leadership program and Fully at the Table. The next three years will be about nurturing those seeds for real growth.

**How are we doing?**
Current baseline results: In the 2012 employee and physician survey, 35% of respondents indicated a response of 4.5 or higher out of 5.0 with regard to accountability. There were no statistically significant differences between physicians and employees.

**What are we doing about this?**
Steven Soroka, Vice-President, Medicine, and Kathy McNeil, Vice President, People, have convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Set clear standards and expectations  
2. Communication performance feedback/enhance career development  
3. Support manager accountability using a competency development process for managers

[last updated August 2013]
4 Innovating Health and Learning

4.1 Research Funds from Grants & Contracts

What is being measured?
Capital Health Research Services manages more than 1040 research accounts (funded projects) supporting 1225 active research projects (funded and unfunded), and is responsible to ensure that all legal, financial and ethical requirements and approvals for research at Capital Health are fulfilled. There are 280 research employees who are integral members of the interdisciplinary healthcare teams providing quality patient-centered care at Capital Health. Capital Health researchers have been the recipients of several large awards. These awards tend to be multidisciplinary in nature and involve a variety of researchers with diverse knowledge and expertise. Additional project management resources have been provided to ensure these projects are successful at every level.

This indicator is the total new dollars in grant and contract research funds received during the fiscal year.

How are we doing?
Total research funds broken down into grants and contracts are shown in the graph below. For 2012/13, both grants and contracts are down from the previous year.

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<td>$5,004,082</td>
<td>$14,997,632</td>
</tr>
<tr>
<td>2009/10</td>
<td>$8,580,795</td>
<td>$6,095,198</td>
<td>$14,675,993</td>
</tr>
<tr>
<td>2010/11</td>
<td>$9,485,073</td>
<td>$4,739,574</td>
<td>$14,224,647</td>
</tr>
<tr>
<td>2011/12</td>
<td>$10,369,811</td>
<td>$6,891,709</td>
<td>$17,261,520</td>
</tr>
<tr>
<td>2012/13</td>
<td>$9,354,823</td>
<td>$6,349,292</td>
<td>$15,704,752</td>
</tr>
</tbody>
</table>

Frequency Tracked: Annually  Last Updated: July 2013  Next Update Expected: Summer 2014
4.2 Focus on Innovation that has Benefits for Patients & Aligns with Our Mission.

**Strategy:** Innovating Health and Learning

**Goal:** New innovations are demonstrably aligned with organizational goals, have clear benefits for patients, and contribute to sustainability.

**Measure:** Implementation of a health technology assessment process for all new major capital equipment expenditures over $500,000, and all new externally provided diagnostic testing which costs more than $10,000 annually per type of test.

**What is being measured?**

To fulfill this goal, we need to implement a new health technology assessment process. Currently, we don’t have such a process in place – in a sense, that’s our baseline.

This process will cover all major capital equipment expenditures over $500,000 and all new types of diagnostic testing provided by an external supplier and projected to cost over $10,000 annually. Of course, we’re in the early stages on this and there is a lot more engagement and input to come from clinical groups on what this process will cover.

**Why is it important?**

A Health Technology Assessment is a best practice, evidence-based approach to ensure expenditures are aligned with our strategies, benefit our patients, and realize cost efficiencies. It is a methodological approach to making decisions.

There are two elements to this: first, rigorous evaluation and prioritization to ensure innovations align with our priorities at Capital Health; second, translating innovations into improvements in care and services.

**How are we doing?**

Current baseline results are not yet available.

**What are we doing about this?**

Catherine Gaulton, Vice-President, Performance Excellence & General Counsel, and Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan. Two major actions for achievement of this 2016 goal are:

1. Implementation of health technology assessment to new capital equipment purchases over $500,000 and other capital processes as recommended by Capital Funding Committee and approved by LET.
2. Implementation of NS-based health technology assessment process to all qualifying diagnostic processes and to other diagnostic processes as recommended by Lab Utilization Committee and approved by LET.

[Last updated: August 2013]
4.3 Strengthen Partnerships with Learning Institutions

**Strategy:** Innovating Health and Learning  
**Goal:** Partners in the academic health learning network report a high degree of quality in their relationship.  
**Measure:** 85% positive response by academic partners on survey items related to the quality of the partnership.

**What is being measured?**  
We sent an online survey to 11 senior leaders at our key partnering academic institutions, asking them about the quality of our partnership with respect to both research and education.

We only received three responses, so the baseline is not concrete. We will look to increase both the response rate and the rate of positive results. Our target is to have 85% positive responses from our partners.

**Why is it important?**  
Simply, if we are not performing at the highest possible level with regard to education, research and innovation, we won’t be improving care at Capital Health.

We are committed to strengthening our ties to learning institutions across the Maritimes — connecting directly to our academic mandate. As an academic health science network, we have a unique role to play in fostering relationships among learning organizations.

**How are we doing?**  
Current baseline results: In the partner survey, respondents rated the quality of our partnership with regard to both research and education at 66%.

**What are we doing about this?**  
Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan. A major action for achievement of this 2016 goal is to further discussions with key researchers at the key educational institutions to gather information and identify barriers to enhance research relationships, ease research approval and facilitate innovation within universities and CH.

[Last updated August 2013]
4.4 Build our Capacity for Interprofessional Research and Interprofessional Education

**Strategy:** Innovating Health and Learning

**Goal:** Increase opportunities for interprofessional research and interprofessional education

**Measure:** 50% increase in the percentage of new, Research Ethics Board approved research initiatives that are interprofessional, and in the number of hours of interprofessional education offered annually

What is being measured?
Although we are measuring increased interprofessional capacity for both research and education in this goal, they are actually quite different areas. We will require two baselines and measures. We feel we can address both initiatives with a common target of a 50% increase in results.

We’ve chosen number of hours as our measure for interprofessional education, and the percentage of new, Research Ethics Board approved interprofessional initiatives as our measure for research.

Why is it important?
The Canadian Institute of Health Research and other research funding bodies are moving to make it a requirement that research initiatives be interprofessional – we are falling in line with a national trend.

This goal relates to our efforts to strengthen collaboration – around chronic disease management, for example. It also connects directly to our focus on improving the quality of care in transitions.

Professions tend to focus on what makes them distinct – we need to work hard to focus on what we hold in common, and by doing that we can transform care.

How are we doing?
Current baseline results: In 2012, 45 of 260, or 17%, newly funded research projects were interprofessional.

According the 2009 inventory of corporate and clinical education, 1500 hours of the total, or 13%, were dedicated to interprofessional education.

What are we doing about this?
Kathy MacNeil, Vice-President, People, and Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

1. Clinical professional development advances acquisition and demonstration of interprofessional competencies. Corporate education facilitates interprofessional and cross sector collaboration at a leadership level
2. Interprofessional student placement experiences occur in every clinical area. Responsibility for interprofessional facilitation seamlessly head by the team
3. Simulation initiatives are maximized for advancement of technical skills and team processes

[Last updated August 2013]
5 Sustainability

5.1 Innovate Systems and Processes for Greater Efficiency

Strategy: Sustainability
Goal: Optimize resources to improve organizational (system) performance, quality and efficiency.
Measure: 60% of typical cases for identified Case Mix Groups have an ALOS equal to or less than the ELOS

What is being measured?
This goal is being looked at from the perspective of optimizing the use of clinical resources. As a result, the measure relates to average length of stay (ALOS) and expected length of stay (ELOS). ALOS is measured based on the length of stay for patients at Capital Health with a particular diagnosis. ELOS is the objective or target – how long patients with that diagnosis would be expected to be in hospital, which is derived from national data.

The main focus will be on three case mix groups (CMGs): heart failure without coronary angiogram, chronic obstructive pulmonary disease, and ischemic event of central nervous system (but not to the exclusion of other CMGs). This is also for typical cases only.

Why is it important?
The focus is on these three groups because of the need for improvement in these areas. If addressed, there will be improvement in the overall results. These 3 areas are in the top 10 CMGs by volume. Results in these areas connect well with other key indicators being tracked.

Finally, and importantly, there is a strong correlation between these areas and Emergency Department flow. Delays in discharging patients in these CMGs affect the whole system – right back to the patient in Emergency waiting for a bed.

How are we doing?
For the complete 2013/14 fiscal year, the percentage of typical cases for the three CMGs with an ALOS equal to or less than the ELOS was 48%. This is a decrease from the baseline of 51% and short of the 2013/14 target of 52%. Individual CMG percentages were:
- Heart failure without Coronary Angiogram: 46%
- Chronic Obstructive Pulmonary Disease: 49%
- Ischemic Event of Central Nervous System: 47%

What are we doing about this?
- For heart failure patients, a multidisciplinary committee has been formed involving all areas who care for heart failure patients to look at the ALOS vs. ELOS issue.
- A review of data identified the Cardiology Unit (6.2) as the biggest concern related to the LOS for heart failure patients.
- A national scan was done looking for Clinical Pathways for heart failure that have already been implemented in other jurisdictions. Results will be reviewed at an upcoming meeting.
- The multidisciplinary committee will also look at barriers to early discharge for this CMG and devise a plan to overcome these barriers.

[Last updated: April 2014]
5.2 Develop Funding Models Based on our Priorities

**Strategy:** Sustainability

**Goal:** All 14 areas of focus are transitioned to funding models based on leading practices.

**Measure:** 100% implementation of funding formulas based on our priorities, using leading practice where available.

**What is being measured?**

This goal and its measure are important indicators in their own right, ensuring we are making progress on our strategic plan. They will enable our success with regard to the other 13 goals.

This work is fairly straightforward. We just need to get on with the work and put the models and formulas in place. It will take time, of course, and we don’t expect we will find many leading practices to adopt - we’ll actually be breaking new ground.

**Why is it important?**

Unfortunately, we know that in health care, sometimes we embark on initiatives without giving them the necessary resources. This goal is about changing that.

The most significant impact of this goal, and its measure, is that we will have a process in place to help us be intentional about the trade-offs we need to make with our resources.

We cannot do everything, and we need to ensure that our strategic priorities are funded while advancing other key indicators. There are challenging times ahead, and the process we put in place will help us move through them.

**How are we doing?**

In the baseline year of 2012/13, none of the Areas of Focus had funding models based on leading practices.

**What are we doing about this?**

Amanda Whitewood, Vice-President, Sustainability and Chief Financial Officer, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

- Review existing budgeting and business planning processes
- Design engagement process for leaders
- Implement funding formulas

[Last updated August 2013]
5.3 Be Better Environmental Stewards

**Strategy:** Sustainability  
**Goal:** Capital Health is independently recognized as a leader in adopting practices and processes that minimize the impact on the environment.  
**Measure:** 15% reduction in total annual electrical power consumption.

**What is being measured?**  
Originally, we saw the work of developing our measure as finding an independent body to review our practices and processes, and target an improvement in their assessment of our progress.

What we quickly realized in our discussions is that the actual result is what is key. So we have chosen a significant environmental indicator – power use – and established a challenging target.

Over the past two years our power use has been trending upwards. We want to stop that climb, and begin to reverse it, by achieving a 15% real reduction in power consumption in three years.

**Why is it important?**  
As a major organization in this region, we are accountable to our larger community, and can play an important role in reducing our environmental impact.

We are working closely with Efficiency Nova Scotia, a recognized independent body, to achieve this important goal.

**How are we doing?**  
Current baseline results: Our baseline is a total organizational kWh usage, including totals from all facilities. In 2012, our total power usage was 83,831,773 kWh.

**What are we doing about this?**  
Amanda Whitewood, Vice-President, Sustainability and Chief Financial Officer, has convened an action team to develop an action plan. Three major actions for achievement of this 2016 goal are:

- Implement sustainable sources of internal funding dedicated to efficiency projects
- Establishment of Embedded Energy Advisor position
- Create a list of projects, prioritized and reviewed annually

[Last updated August 2013]
### Appendix A: Patient Safety Scorecards

#### LEGEND

<table>
<thead>
<tr>
<th>Not meeting target</th>
<th>Almost meeting target</th>
<th>Meeting target</th>
<th>No established target or data not available</th>
</tr>
</thead>
</table>

#### Table A1: Scorecard for Quarterly-Trending Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>Q1 11/12</th>
<th>Q2 11/12</th>
<th>Q3 11/12</th>
<th>Q4 11/12</th>
<th>Q1 12/13</th>
<th>Q2 12/13</th>
<th>Q3 12/13</th>
<th>Q4 12/13</th>
<th>Q1 13/14</th>
<th>Q2 13/14</th>
<th>Q3 13/14</th>
<th>Q4 13/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Acquired Infections</td>
<td>MRSA Transmission (per 10,000 patient days)</td>
<td>&lt; 12.44</td>
<td>2.9</td>
<td>4.6</td>
<td>3.2</td>
<td>5.3</td>
<td>3.8</td>
<td>6.7</td>
<td>3.5</td>
<td>4.7</td>
<td>4.5</td>
<td>4.6</td>
<td>3.4</td>
<td>3.0</td>
</tr>
<tr>
<td></td>
<td>C. difficile Incidence (per 10,000 patient days)</td>
<td>&lt; 6.0</td>
<td>2.9</td>
<td>3.3</td>
<td>1.4</td>
<td>2.0</td>
<td>2.0</td>
<td>3.1</td>
<td>3.0</td>
<td>3.9</td>
<td>5.0</td>
<td>3.4</td>
<td>2.9</td>
<td>3.9</td>
</tr>
<tr>
<td></td>
<td>VRE Incidence (per 10,000 patient days)</td>
<td>&lt; 8.6</td>
<td>0.0</td>
<td>0.0</td>
<td>7.9</td>
<td>0.7</td>
<td>3.0</td>
<td>0.7</td>
<td>0.3</td>
<td>0.3</td>
<td>1.9</td>
<td>1.4</td>
<td>1.5</td>
<td>0.9</td>
</tr>
<tr>
<td>DGH Quick Response Team</td>
<td>DGH Code Blue Count (Average codes per month)</td>
<td>≤ 3</td>
<td>1.3</td>
<td>2.3</td>
<td>1.7</td>
<td>3.3</td>
<td>2.3</td>
<td>0.7</td>
<td>0.7</td>
<td>2.7</td>
<td>3.0</td>
<td>1.0</td>
<td>2.0</td>
<td>1.3</td>
</tr>
</tbody>
</table>

#### Table A2: Scorecard for Calendar Year Annually-Trending Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>Jan-Mar 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand Hygiene</td>
<td>Compliance Before Patient Contact</td>
<td>80%</td>
<td>29%</td>
<td>54%</td>
<td>46%</td>
<td>60%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Compliance After Patient Contact</td>
<td>80%</td>
<td>55%</td>
<td>75%</td>
<td>74%</td>
<td>81%</td>
<td>81%</td>
</tr>
<tr>
<td></td>
<td>Overall Compliance</td>
<td>80%</td>
<td>44%</td>
<td>66%</td>
<td>61%</td>
<td>72%</td>
<td>74%</td>
</tr>
</tbody>
</table>

#### Table A3: Scorecard for Fiscal Year Annually-Trending Indicators

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>Hospital Standardized Mortality Ratio (HSMR)</td>
<td>≤ 100</td>
<td>109</td>
<td>113</td>
<td>105*</td>
<td>99</td>
<td>107</td>
<td>99 (Q1–Q3)</td>
</tr>
<tr>
<td>Patient Safety Culture Survey</td>
<td>“Excellent” &amp; “Very Good” Responses</td>
<td>47%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Acceptable” Responses</td>
<td>44%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Poor” and “Failing” Responses</td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of “Excellent”, “Very Good”, and “Acceptable” Responses Combined</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Patient Safety Training</td>
<td>Documentation of Percentage Completion in LMS</td>
<td>100%</td>
<td>30%</td>
<td>31%</td>
<td>25%</td>
<td>39%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Patient Experience Survey –</td>
<td>Percentage of “Agree” responses to: Staff consistently washed hands</td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
<td>88%</td>
<td>89%</td>
<td>86%</td>
<td>86% (Apr – Dec)</td>
</tr>
<tr>
<td>Concern for Safety: Inpatient</td>
<td>before providing care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&amp; Organizational Results</td>
<td>Percentage of “Agree” responses to: Before giving medications, did staff</td>
<td>90%</td>
<td>87%</td>
<td>86%</td>
<td>86%</td>
<td>86%</td>
<td>67%</td>
<td>67% (Apr – Dec)</td>
</tr>
<tr>
<td></td>
<td>tell you what the medicine was for?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of “Agree” responses to: Hospital staff described possible side</td>
<td>90%</td>
<td>69%</td>
<td>69%</td>
<td>67%</td>
<td>69%</td>
<td>68%</td>
<td>70% (Apr – Dec)</td>
</tr>
<tr>
<td></td>
<td>effects in a way that was understandable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of “Yes” responses to: Told what you could do to make sure</td>
<td>90%</td>
<td>69%</td>
<td>68%</td>
<td>70%</td>
<td>68%</td>
<td>70%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>you were safe in hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* The HSMR score can be listed as greater than 100 and still be meeting the target if the score is NOT reported to be statistically significantly different from the 2009/10 national average.

Capital Health’s Strategic Indicators Report, June 20, 2014
## Appendix B: Access (Wait Times) Scorecard

### Table B1: Target and Actual Wait Times for Key Treatments/Procedures at Capital Health

<table>
<thead>
<tr>
<th>Treatment / Procedure</th>
<th>Target Wait Time</th>
<th>Average Wait Times for April 2014 (except where noted)</th>
<th>Location</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Computed Tomography (CT)</td>
<td>28 days</td>
<td>31 days</td>
<td>Capital Health</td>
<td>Not meeting target</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>28 days</td>
<td>264 days</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Radiotherapy – Intermediate Cases</td>
<td>14 days</td>
<td>17 days</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Radiotherapy – Urgent Cases</td>
<td>7 days</td>
<td>6 days</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>62% of cases completed within target (Q4 2013/14)</td>
<td>Capital Health</td>
<td>Not meeting target</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>35% of cases completed within target (Q4 2013/14)</td>
<td>Capital Health</td>
<td>Almost meeting target</td>
</tr>
<tr>
<td>Hip Fracture Repair</td>
<td>100% of cases completed within 48 hours</td>
<td>67% of cases completed within target (Q4 2013/14)</td>
<td>Capital Health</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>100% of cases completed within 16 weeks</td>
<td>73% of cases completed within target (Q4 2013/14)</td>
<td>Capital Health</td>
<td>Meeting target</td>
</tr>
<tr>
<td>CABG – Urgent Cases</td>
<td>7 days</td>
<td>14 days (median wait time)</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td>CABG – Semi-Urgent Cases</td>
<td>21 days</td>
<td>19 days (median wait time)</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td>CABG – Scheduled Cases</td>
<td>42 days</td>
<td>22 days (median wait time)</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td>ED – 90th Percentile Wait Time from Triage to Admission</td>
<td>8 hours</td>
<td>22 hours (90th percentile)</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 hours (90th percentile)</td>
<td>DGH</td>
<td>Meeting target</td>
</tr>
<tr>
<td>ED – Average Wait Time from Triage to Physician: CTAS Level 3 (Urgent)</td>
<td>30 minutes</td>
<td>157 minutes</td>
<td>QEII</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>155 minutes</td>
<td>DGH</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>85 minutes</td>
<td>CCHC</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>69 minutes</td>
<td>HCH</td>
<td>Meeting target</td>
</tr>
</tbody>
</table>
Appendix C: Strategic Streams

This report has been organized around Capital Health’s Five Strategic Streams:

**Person-Centered Health Care**  – Person-centered health welcomes the patient as a full-fledged member of the health care team, respects their ownership and rights to their own health, and recognizes that a healthy person needs a healthy community. Capital health will care for the whole person before us with our hearts, as well as our hands and minds.

**Sustainability**  - Capital Heath is transforming health care today because we want to be here for the people of our communities for a very long time. We are working to ensure our workforce will be sufficient to care for those we serve; buildings will be designed with the needs of patients citizens and the environment in mind; and all of this will happen on a budget that will not break the bank.

**Transformational Leadership**  - Capital Heath invites every person to share their talents, act with passion and purpose, listen deeply, grow relationships, take risks and embrace tension to co-create a world-leading haven for people-centered health, healing and learning. We will focus on matching peoples' passion, talents and sense of purpose to the work rather than just focusing on the technical aspects of the job. We will create a culture and environment that fosters joy, pride, trust, and respect.

**Citizen Engagement & Accountability**  - Capital Health is opening our doors, our minds, and our ears to connect with what communities really need. We are committed to a health system where each of us shares in the accountability for our individual health, the health of our health system and that of our community.

**Innovation & Learning**  - Capital Health will contribute to a better tomorrow as lifelong learners, educators of the next generation, and researchers of new frontiers in health and healing. We will keep the spark of curiosity alive, and encourage it in everyone—whether they’re at the bedside, in the boardroom, or in the lab. Constantly asking why will help us find a better way.
Appendix D: Quality and Patient Safety Framework

The Integrated Quality and Patient Safety Framework shown below outlines the quality and patient safety structure, functions, responsibilities and accountabilities at Capital Health. The framework is not a stand alone document – it is supported by Our Promise, Our Declaration of Health, the Patient Safety Plan, our Strategic Indicators Reporting Framework, Capital Health Ethics Framework, Research Ethics Framework, and our foundation as an academic health sciences network. It provides information and guidance to the organization for selection and measurement of our achievements in service quality, care outcomes, and risk mitigation. It is not intended to be a detailed procedure for designing or implementing quality and patient safety initiatives. The framework is reviewed on a regular basis to ensure continued alignment with the vision mission and strategic direction of Capital Health.

This framework was developed in 2010 and first appeared in the October 2010 version of this report—replacing the Framework for Developing and Reporting of Operational Measures.
In addition, each indicator found within Capital Health’s Strategic Indicators Report falls into one of the eight Qmentum quality dimensions outlined by Accreditation Canada (http://www.accreditation.ca/en/default.aspx ). The quality dimensions are listed below.

Qmentum Quality Dimensions:

**Population Focus** - working with communities to anticipate and meet needs

**Accessibility** - providing timely and equitable services

**Safety** - keeping people safe

**Worklife** - supporting wellness in the work environment

**Client-centred services** – putting clients and families first

**Continuity of Services** – experiencing coordinated and seamless services

**Effectiveness** - doing the right thing to achieve the best possible results

**Efficiency** - making the best use of resources
Appendix E: Our Promise in Action Poster

Our Promise in Action

Transforming Person-Centred Health Care Experience

Putting those we serve – patients, families, communities – at the centre of our work. Reckless pursuit of excellence in care and service.

AREA of FOCUS: Strengthen community-based care for chronic disease.
GOAL: Significant increase over baseline of chronic disease management occurring in the community where appropriate.
MEASURE: 8% reduction in the number of return outpatient visits annually at selected clinics in relation to hypertension, heart disease, COPD, and diabetes.

AREA of FOCUS: Improve quality of care in transitions.
GOAL: Care teams will improve achievement in meeting established standards in the quality of care at key transition points substantially over 2012 baseline levels.
MEASURE: 50% overall compliance in documenting patient instructions on the discharge summary.

Capital Health’s Strategic Indicators Report, June 20, 2014
Appendix F: Summary of the 14 Areas of Focus with Respect to the 2013/14 Targets

This section will be completed when 2013/14 targets are established and progress measures are available for the 14 Areas of Focus.
Appendix G: Contributors

Many people contributed to the preparation of this report. In particular:

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Their contributions of data, background information, and insights enrich this report and are gratefully acknowledged.