CENTRAL ZONE’S STRATEGIC INDICATORS REPORT

OCTOBER 2015

Prepared by Decision Support
October 23, 2015
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 contains a summary of the progress of the 14 Areas of Focus with respect to the 2013/14 targets.

- ✔ 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 *

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<td><strong>Access Indicators</strong></td>
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<tr>
<td>✔</td>
<td>Surgery Cancellation Rates</td>
<td>In September 2015, the resource-related surgery cancellation rate was 3.3%. This is short of the target of 1.7%.</td>
<td>8</td>
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<tr>
<td>✔</td>
<td>Wait Times – Elective CT</td>
<td>The August 2015 wait time was 24 days—better than the target of 28 days.</td>
<td>10</td>
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<tr>
<td>✔</td>
<td>Wait Times – Elective MRI</td>
<td>In August 2015, the average wait time for MRI was 173 days—over six times longer than the target of 28; however, a trend of improvement can be seen over the past 2 years.</td>
<td>11</td>
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<tr>
<td>❌</td>
<td>Wait Times - Radiotherapy Treatment</td>
<td>In August 2015, radiotherapy wait times were longer than target for both urgent and intermediate cases.</td>
<td>12</td>
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<td>✔</td>
<td>Wait Times – Hip Fracture Surgery</td>
<td>In Q1 of 2015/16, 82% of cases met the target wait time of 48 hours. This is short of the target of 100%, but, along with the previous two quarters, is the best the rate has been in at least five years.</td>
<td>14</td>
</tr>
<tr>
<td>❌</td>
<td>Wait Times – Hip Replacement</td>
<td>In Q1 of 2015/16, only 66% of cases met the target wait time of 182 days.</td>
<td>15</td>
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<td>✔</td>
<td>Wait Times – Knee Replacement</td>
<td>In Q1 of 2015/16, only 31% of patients had their knee replacement surgery within the target time of 182 days</td>
<td>16</td>
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<td>✔</td>
<td>Wait Times – Cataract Surgery</td>
<td>In Q1 of 2015/16, only 73% of cases met the target wait time of 16 weeks.</td>
<td>17</td>
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<td>✔</td>
<td>Wait Times – Open Heart Surgery</td>
<td>In July 2015, semi-urgent and scheduled cases were meeting target, but urgent cases were not.</td>
<td>18</td>
</tr>
<tr>
<td>❌</td>
<td>Wait Times – From Triage to Admission in the Emergency Department</td>
<td>Both the QEII and DGH are above the 8-hour target for the 90th percentile wait time (unfavourable).</td>
<td>19</td>
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<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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<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Wait Times – Priority Interventions</td>
<td>None of the four priority interventions is meeting its target.</td>
<td>21</td>
</tr>
<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Patient Safety Indicators</td>
<td></td>
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<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Incidence Rates – MRSA</td>
<td>Central Zone rates are below the 2012 national rate.</td>
<td>22</td>
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<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Incidence Rate – VRE</td>
<td>Central Zone rates are below the 2012 national rate.</td>
<td>23</td>
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<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Infection Rate – C. difficile</td>
<td>Central Zone rates are below the 2012 national rate.</td>
<td>24</td>
</tr>
<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Hand Hygiene Compliance</td>
<td>For Jan-Jun of 2015, the overall rate was 79%—just short of the target of 80%. The “before” rate was 68% (short of the target) and the “after” rate was 86% (exceeding the target).</td>
<td>25</td>
</tr>
<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Hospital Standardized Mortality Ratio</td>
<td>In 2013/14, CDHA’s HSMR showed no statistically significant difference from the 2009/10 national average.</td>
<td>26</td>
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<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Patient Experience Survey</td>
<td>In 2014/15, the positive response target of 90% was exceeded in five of eight patient experience dimensions.</td>
<td>27</td>
</tr>
<tr>
<td>❏</td>
<td>Patient Safety Culture</td>
<td>No target set. The 2012 survey shows improvement over the 2010 and 2006 surveys.</td>
<td>29</td>
</tr>
<tr>
<td>✔ ✔</td>
<td>Completion of Patient Safety Training</td>
<td>For 2014/15, 70% completed at least one patient safety training course. This is short of the target of 100%.</td>
<td>30</td>
</tr>
<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Additional Transforming the Person-Centred Health Care Experience Indicators</td>
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<tr>
<td>❖</td>
<td>Length of Stay – Number of Conservable Days</td>
<td>If the trend in the first three months of 2015/16 continues for the rest of the fiscal year, conservable days will be over target (unfavourable).</td>
<td>31</td>
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<tr>
<td>✔ ✔</td>
<td>Occupancy Rates</td>
<td>For Apr. to Sep. of 2015, the QEII was below the 90% occupancy rate target (favourable) but the DGH was above this target (unfavourable).</td>
<td>32</td>
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<tr>
<td>✔ ✔ ✔ ✔</td>
<td>Emergency Department – Left Without Being Seen</td>
<td>Each of the four sites is over the 2% target (unfavourable).</td>
<td>34</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>35</td>
</tr>
<tr>
<td>❖</td>
<td>Strengthen Community-Based Care for Chronic Disease</td>
<td>Baseline measurement only at this time. No change from baseline planned until 2015/16. Deliverables are on track for completion.</td>
<td>37</td>
</tr>
<tr>
<td>✔ ✔</td>
<td>Improve Quality of Care in Transitions</td>
<td>The 2013/14 discharge summary reports audit showed a 60% compliance rate. This exceeds the 25% target.</td>
<td>38</td>
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<tr>
<td>❖</td>
<td>Build a Culture of Customer Service</td>
<td>The results are short of the 2013/14 targets and even slightly lower than the baseline results in 2012/13.</td>
<td>39</td>
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<tr>
<td><strong>Citizen and Stakeholder Engagement and Accountability</strong></td>
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<tr>
<td><strong>B</strong></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. No measure for 2013/14. Work has been done to identify target populations and approaches.</td>
<td>41</td>
</tr>
<tr>
<td>✔️</td>
<td>Involve Patients Directly in Their Care</td>
<td>In 2013/14, the percentage of respondents who agreed they or their family were consulted in making decisions about their care was 78.9%—just over the target of 78.8%.</td>
<td>42</td>
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<tr>
<td><strong>B</strong></td>
<td>Lead Dialogue with the Public Addressing Appropriateness of Care</td>
<td>This goal area received no funding in year one to implement any of the initiatives identified in the original action plan so little-to-no progress was made on the action plan and a follow-up survey to measure progress was not contracted.</td>
<td>43</td>
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<td><strong>Transformational Leadership</strong></td>
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<tr>
<td>✗</td>
<td>Absenteeism</td>
<td>The average for April to August 2015/16 was 8.4 sick hours per employee per month—higher than the target of 6.15 (unfavourable).</td>
<td>45</td>
</tr>
<tr>
<td>✔️</td>
<td>Overtime</td>
<td>For April-Jul 2015, the rate was 1.40% which is below the target of 1.89%.</td>
<td>46</td>
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<tr>
<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>
<td>47</td>
</tr>
<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>48</td>
</tr>
<tr>
<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 Central Zone management and engagement with Central Zone had the lowest.</td>
<td>49</td>
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<tr>
<td>✗</td>
<td>Improve Leadership Capacity at all Levels</td>
<td>Two of the three dimensions showed improvement over the 2012/13 baseline, but none of them met its respective 2013/14 target.</td>
<td>50</td>
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<td>✗</td>
<td>Strengthen Accountability of Employees and Physicians.</td>
<td>The 2013/14 target was not met. Results actually showed a decline from the 2012/13 baseline.</td>
<td>52</td>
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<td><strong>Innovating Health and Learning</strong></td>
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<tr>
<td>●</td>
<td>Research Funds from Grants &amp; Contracts</td>
<td>For 2013/14, both grants and contracts were up from the previous year. Funds from grants rose significantly.</td>
<td>54</td>
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<td><strong>B</strong></td>
<td>Focus on Innovation that has Benefits for Patients &amp; Aligns with Our Mission.</td>
<td>The attainment of this year’s goal is directly related to having a Health Technology assessment capability in the Central Zone and that is in turn directly related to conversations provincially on health technology assessment.</td>
<td>55</td>
</tr>
<tr>
<td><strong>B</strong></td>
<td>Strengthen Partnerships with Learning Institutions</td>
<td>Baseline measurement only at this time. An update for 2013/14 was not provided.</td>
<td>56</td>
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<tr>
<td>✔</td>
<td>Build our Capacity for Interprofessional Research and Interprofessional Education</td>
<td>The 2013/14 target was met for education. Update for research results was not provided.</td>
<td>57</td>
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### Sustainability

| ✔ | Innovate Systems and Processes for Greater Efficiency | For Q1 of 2015/16, the rate for the three CMGs combined was 41%—short of the target of 60%. | 58 |
| B | Develop Funding Models Based on our Priorities | Approximately $1.5M–$2M has been allocated towards Our Promise in Action action plans in the 2014/15 fiscal year’s budget. | 59 |
| ✔ | Be Better Environmental Stewards | For 2013/14, there was a decrease from the baseline kWh of 5.8%. This is better than the target of a 5% reduction for 2013/14. | 60 |
| n/a | Implementation of the Electronic Health Record | Central Zone’s efforts to implement an EHR have stalled due to the province’s desire to have a single health information solution. | 61 |
| ✔ | Actual Expenditure to Approved Budget | Actual expenditure showed a variance of 0.44 % over the approved budget. | 62 |
| ✔ | Focus on Sustainability | Percentage of approved funding requests was below target for infrastructure, clinical equipment, and equipment. | 63 |
| ✔ | Improve Population Health | In 2013-14, the Central Zone actively contributed to five major public policies. This exceeds the target of two. | 64 |

### Appendices

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Introduction

Central Zone’s Strategic Indicators Report is a stimulus for quality improvement as it provides multi-year data on key indicators identified by Central Zone stakeholders. Over the summer and fall of 2009, leaders within the Central Zone 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 Central Zone 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 D provides a detailed description of the strategic streams. Indicators in this report fall under these five streams.

The Quality and Patient Safety Framework (Appendix E) is also based around these five strategic streams (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, Central Zone’s strategic plan has been renewed for the subsequent 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 F. Each of the 14 Areas of Focus is presented in this report under its own section. Progress of the 14 Areas of Focus against the 2013/14 targets is summarized in Appendix C.

For additional information on the Central Zone’s “Our Promise in Action”, please visit the Central Zone 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 Central Zone Strategic Indicators Report will be posted on the Central Zone’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. Central Zone 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. Central Zone does not endorse, warrant or guarantee the products, services or information described or offered at any other Internet sites. Central Zone 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 Central Zone people. Those who are to be acknowledged for their valued contributions are listed in Appendix G.
1 Transforming the 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 (unfavorable) since December 2012, but dipped below target (favorable) in February 2014. In April 2014, the resource-related cancellation rate shot up to 10.6% because of a nursing strike. The rate has since come back to its usual range although still not within the target rate. The rate increased again in April 2015 related to sterilization challenges in SPD. The rate has since decreased but is still above target.

Three key contributing factors to resource-related cancellations in July 2015 were:
- Emergency bumps (29 cases) – there were 24 cases at the HI (CV/Ortho/Plastics/Gen Surgery/ Neuro) and 5 cases at the VG (ophthalmology/GenSurg) and none at DGH.
- Lack of elective time and previous Case Over run (15 cases) – much dispersed across 3 sites VG/HI/DGH and specific service. Reminder these are often associated with emergency bumps.
- ICU bed not available (11 cases) – 9 cases at the HI (CVS/Vasc) and 2 at the VG (Gen Surg/Thoracic)
- Further evaluation (6 cases)

Patient-related cancellations have been below the target rate of 1.7% since April 2014; however, in January to March of 2015, the rate was over target, mostly related to inclement weather and patient travel issues. From July to September 2015, the rates were below target (favourable).

What are we doing about this?
A recovery plan was developed following the sterilization challenges at the QEII which included realignment of OR time and additional OR rooms. As a result of this recovery plan, over 90% of canceled surgeries have been rebooked and completed. [Text last updated September 2015]
Central Zone’s Surgical Cancellation Rates

Resource & Patient-Related Reasons

Patient- and Hospital-Related Surgical Cancellation Rates & Total Surgeries for Recent Months

<table>
<thead>
<tr>
<th>Facility</th>
<th>August 2015</th>
<th></th>
<th>September 2015</th>
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<tbody>
<tr>
<td></td>
<td>Patient-Related Cancellations</td>
<td>Resource-Related Cancellation</td>
<td>Total Surgeries</td>
<td>Patient-Related Cancellations</td>
<td>Resource-Related Cancellations</td>
<td>Total Surgeries</td>
</tr>
<tr>
<td>HI</td>
<td>0.7%</td>
<td>3.1%</td>
<td>916</td>
<td>0.5%</td>
<td>3.8%</td>
<td>1,115</td>
</tr>
<tr>
<td>VG</td>
<td>1.0%</td>
<td>1.5%</td>
<td>792</td>
<td>1.0%</td>
<td>3.0%</td>
<td>1,574</td>
</tr>
<tr>
<td>DGH</td>
<td>1.5%</td>
<td>2.6%</td>
<td>343</td>
<td>3.3%</td>
<td>3.9%</td>
<td>512</td>
</tr>
<tr>
<td>HCH</td>
<td>3.6%</td>
<td>0.0%</td>
<td>55</td>
<td>0.0%</td>
<td>0.0%</td>
<td>67</td>
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Frequency of Data Updates: Monthly  
Data Last Updated: Oct. 2015  
Next Data Update Expected: Nov. 2015
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. Central Zone 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 in the Central Zone. This is the average for the QEII, Dartmouth General, and the Cobequid Community Health Centre combined. The target wait time is 28 days. The August 2015 wait time was 24 days.

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

What are we doing about this?
Central Zone continues to work to reduce wait times for CT exams. Patients are booked for examinations using a centralized process that ensures that a patient will be booked at the earliest acceptable time throughout the district. [Last updated February, 2015]
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 Central Zone 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. Central Zone 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 August 2015, the average wait time for MRI was 173 days—over six times longer than the target of 28 days. However, the wait time continues on an overall trend of improvement.

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

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

What are we doing about this?
On December 8, 2014, Central Zone opened a new high field strength (3 Tesla) MRI unit at the Halifax Infirmary site. This unit is shared with research and will allow an additional 37.5 hours per week of scan time when all staff have been trained. With this new 3T MRI, the QEII can now scan an additional 50 clinical patients a week. While patients requiring urgent exams will continue to receive MRIs as soon as possible, having the additional 3T will allow Central Zone to lower the elective waitlist over time. [Last updated February 2015]
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 hovering very close to the target of seven days. In January 2014, the wait time was slightly higher than the target because in early January, flooding in the Dickson Building affected the CT simulator used for radiotherapy treatment planning. In September to November 2014, the average waits were slightly above the target but, more recently, from December 2014 to May 2015 the average wait has been below target (favourable). In August 2015, the wait was just over the target at 7.4 days.

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. Most recently, the average wait time was 19 days in August 2015.

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 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 the 2013/14 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: Oct. 2015  
Next Graph Update Expected: Nov. 2015

Central Zone’s Strategic Indicators Report, October 23, 2015
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 within 48 hours. In Q1 of 2015/16, 82% of cases met the target (see graph below). For the last three quarters, the rate is the best it has been in at least five years.

What are we doing about this?
The key change that has improved this is the realignment of one room per week of OR time to orthopedics. When Ortho waitlist volumes go above 12-14 cases, additional Ortho OR time is realigned and/or elective cases are postponed.

[Last updated September 2015]
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 2) 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 Q1 of 2015/16, 66% 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:
- Commitment made from staff and surgeons to consistently book one 4 joint room a day starting Sept 2015.
- 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; and 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.
- Meeting to review target with Division Chief & set more realistic staggered targets will be held (Auditor General recommendation). The target is Sept. 1015.
- OR Executive and Ortho Leadership working to realign HI surgical services to create capacity for increased arthroplasty surgery. Target is for fall 2015 and Jan. 2016.
- Long Waiter Proposal for Arthroplasty Surgery submitted to DOHW and waiting approval.

[Text last updated Sept 2015]
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 goal is to have 100% of all patients’ knee replacement surgeries performed within this target time. In Q1 of 2015/16, only 31% of patients had their knee replacement surgery within the target time.

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:
• Commitment made from staff and surgeons to consistently book one 4 joint room a day starting Sept 2015
• 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; and 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.
• Meeting to review target with Division Chief & set more realistic staggered targets will be held (Auditor General recommendation). Target is Sept. 1015.
• OR Executive and Ortho Leadership working to realign HI surgical services to create capacity for increased arthroplasty surgery. Target fall 2015 and Jan. 2015.
• Long Waiter Proposal for Arthroplasty Surgery submitted to DOHW and waiting approval.

[Last updated September 2015]
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 Q1 of 2015/16, the rate was 73%.

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

What are we doing about this?
- A new OR Schedule was implemented in Q2 of 2014/15 that included a cataract fast track room (a pilot project was completed & was successful).
- Continuing to book 14-day cataract rooms.
- Patient volumes increased in September 2015.

[Last updated Sept 2015]
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 the three urgency categories of CABGs are shown in the graph below.

The median wait time for scheduled cases (shown in green) was longer than target for March to June 2015, but was below target for July. The median wait time for semi-urgent cases (shown in pink) has been meeting target for June and July 2015. The median wait time for urgent cases (shown in blue) has fluctuated a great deal over the past year but recently, from November 2014 to July 2015, the median waits were over the target of 7 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 October 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— as outlined in Better Care Sooner, the plan to improve emergency care in Nova Scotia. Both the QEII and DGH sites have 90th percentile waits that are longer than the target of eight hours. See the graph below.

For additional emergency-department indicators, click here to go to the Central Zone 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) 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 a triage RN role and having Pod 5 hours extended since Sep. 2013. The care model now includes CTAs to allow flexibility 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 September 2014]
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. 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 Central Zone 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) 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. HI ED pod 5 continues to assist with wait times for CTAS 4 and 5 patients.

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 September 2014]

Central Zone’s Strategic Indicators Report, October 23, 2015
1.12 Wait Times – Priority Interventions

**Strategy:** Patient-Centred Health Care

**Goal:** Meet national benchmarks for service access

**Measure:** Access wait times for designated clinical areas (MRI, hip, knee, and ED (triage to admission))

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**What is being measured?**

Indicators in this section are average, 90th percentile wait times, or the percentage of cases completed with the target time.

**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 and knee replacement surgery, MRIs and emergency waits 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 table below shows the wait time results for MRI, hip replacement, knee replacement, and for triage to admission in the ED. None of these wait times is meeting its target.

To see recent wait times for key health interventions at different locations across 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 Central Zone 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.

Several strategies are in place to increase the number of patients with hip fractures who receive surgery within 48 hours including:

- Any last minute available OR time is being realigned to support orthopedic trauma
- Inpatient Ortho Leadership meetings take place on a monthly basis 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

Strategies are being undertaken to reduce the wait time for knee replacement surgery including:

- Between November 2013 & March 2014 a total of 130 additional hip/knee joint patients that were long waiters were completed – 35 above target.
- A proposal for 2014/15 joints will be submitted to the Department of Health and Wellness.
- 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.

[Last updated July 2014]

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<table>
<thead>
<tr>
<th>Treatment / Procedure</th>
<th>Target Wait Time</th>
<th>Location</th>
<th>Wait Times for August 2015 (except where noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>28 days</td>
<td>QEII</td>
<td>173 days (average)</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Central Zone</td>
<td>66% of cases completed within 26 weeks (Q1 2015/16)</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Central Zone</td>
<td>31% of cases completed within 26 weeks (Q1 2015/16)</td>
</tr>
<tr>
<td>ED – 90th Percentile Wait Time from Triage to Admission</td>
<td>8 hours</td>
<td>QEII</td>
<td>25 hours (90th percentile)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DGH</td>
<td>46 hours (90th percentile)</td>
</tr>
</tbody>
</table>

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Table Update Frequency: Monthly  
Table Last Updated: Oct. 2015  
Next Table Update Expected: Nov. 2015
Patient Safety Indicators

1.13 Incidence Rates – MRSA

What is being measured?
This indicator measures the rate of newly identified cases of MRSA among patients admitted to a Central Zone 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 2012, according to the Canadian Nosocomial Infection Surveillance Program (CNISP) the national incidence rate was 11 per 10,000 patient days. The transmission rates in Central Zone have consistently been below this national rate.

What are we doing about this?
The following prevention and control measures are in place in the Central Zone:

- 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]
1.14 Incidence Rate – VRE

What is being measured?
This indicator measures the rate of newly identified cases of VRE among patients admitted to a Central Zone 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 quarterly rates in the Central Zone have been consistently below this national rate. See the graph below.

What are we doing about this?
The following prevention and control measures are in place in the Central Zone:
- 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]
1.15 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 the Central Zone.

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 Central Zone quarterly rate 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]
1.16 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, Central Zone 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 January to June of 2015, the overall rate was 79%—just short of the target of 80%. The “before” rate was 68% (short of the target) and the “after” rate was 86% (exceeding the target). Results are 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 Central Zone. 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]
1.17 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 2013/14. 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. In 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]
**1.18 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 summarizes the Inpatient and Ambulatory Patient Experience Surveys. Mental Health & Addictions, Cancer Care and Emergency Department patients are not included; they are surveyed separately using different tools. Complete results can be found on our public site by clicking [here](#).

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

**How are we doing?**
In 2014/15 we exceeded our positive response target of 90% in five of eight patient experience dimensions. (see graph below).

From an inpatient perspective we saw increases reflected in 50% of our survey questions; 45% remained steady (less than a 1% change); and two questions decreased: Satisfaction with Surgery Wait Times (from 89% to 84%) and Interpreter Services (consideration should be given to the limitations of an English survey to obtain feedback on this question).

Our highest inpatient gains were experienced in the following areas:
- Concern for safety (all questions rated higher by 2–5%)
- Satisfaction with food (from 55% to 60%)
- Bathroom was kept clean (from 76% to 82%)

This year we focused specific attention on improving our Continuity of Care processes. Gains were made in:
- Information received regarding who to contact if a problem arose (from 87% to 89%)
- Information received in writing regarding symptoms to monitor (from 55% to 60%)

Ambulatory Care patient experience results remained fairly stable as compared to 2013/14 results with no change in 77% of the questions; 15% or 6 questions increased; and 8% or 3 questions decreased. Questions that were rated lower include:
- Emotional support and counseling provided (from 90% to 88%)
- Hospital staff described possible side effects in a way that was understandable (from 86% to 85%)
- Personal references taken into account (from 97% to 95%)

Areas that saw improvements include:
- Received Information regarding who to contacts if a problem arose (from 91% to 93%)
- Conversation regarding supports at home upon discharge (from 69% to 71%)
- Facility cleanliness (from 91% to 94%)

**What are we doing about this?**
Results from the Patient Experience survey are used to guide improvement projects and assess progress at both the organizational and team levels. Service or unit level results and patient comments are brought back to the teams. They use this feedback to guide their specific quality plans and activities. The teams focus their efforts on items patients indicated need improvement within their specific area. Teams are encouraged to share their successful practices with our Quality Leaders group so that others have an opportunity to benefit from their experiences and determine if similar practice might work for their patients. Quality and Patient Safety Leads provide support by meeting with teams to review results and assist in developing improvement initiatives. Support services such as housekeeping, food services and maintenance are provided with patient comments specific to efforts. Specific results are also shared during orientation sessions and quality presentations to highlight the impact our actions can have in areas such as communication. Additional patient feedback is gathered through the Mental Health Patient Survey, the Camp Hill Veterans Services program. [Last Updated September 2015]
Patient Experience Survey Results: Inpatient & Ambulatory Services

<table>
<thead>
<tr>
<th>Dimension of Patient Experience</th>
<th>2011/12</th>
<th>2012/13</th>
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Target = 90% or greater

Graph Update Frequency: Yearly
Graph Last Updated: Sept. 2015
Next Graph Update Expected: Summer 2016
1.19 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. See the graph below.

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 Flash discussion cards and an accompanying resource manual have been developed for use at the service level and have 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.
- Patient Safety First brochures and posters were refreshed and information added on inpatient and ambulatory falls, and safety tips for preventing falls.
- 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.
- Support for Patient Safety Action Plans at the team level.

[Last updated August 2014]
1.20 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, Central Zone requires all employees and volunteers to annually complete at least one patient safety course.

Why is it important?
Everyone working in the Central Zone 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 Central Zone employees, medical staff, learners, and volunteers who completed at least one patient safety course. The annual target is to reach 100%. For the full 2014/15 fiscal year, 70% 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 Central Zone 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 the Person-Centred Health Care Experience Indicators

1.21 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 in a one-year period. For the full 2014/15 fiscal year, conservable days totaled 4,324. This surpasses the target. For the first three months of 2015/16, there were 4,858 conservable days.

What are we doing about this?
Improvement initiatives include:

- 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]
1.22 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?
Central Zone’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 fiscal year 2014/15, the following services were at or below the target of 90% (favourable): QEII Surgical, QEII ICU, QEII Palliative Care, 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.

For April to September of 2015, the same services were above and below the target. The overall rate for the QEII was still below the target (favourable) and the overall rate at the Dartmouth General was still above target (unfavourable).
Graph Update Frequency: Monthly
Graphs Last Updated: Oct. 2015
Next Graph Update Expected: Nov. 2015
1.23 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 Central Zone 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% across the Central Zone. All sites are over the 2% target (unfavourable).

For additional emergency-department indicators, click here to go to the Central Zone 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]
1.24 Long Term Care – Patients Placed & Waiting to be Placed

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 Central Zone sites. These graphs represent LTC patients from all Central Zone 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 Central Zone patients placed and waiting to be placed into LTC facilities. In March 2014, the total number of patients at all Central Zone 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 the Central Zone, 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]
Central Zone Patients *Waiting to be Placed* in LTC

![Graph showing Central Zone Patients Waiting to be Placed in LTC](image)

Central Zone Patients *Placed* in LTC

![Graph showing Central Zone Patients Placed in LTC](image)

Graph Update Frequency: Monthly

Graphs Last Updated: May 2014

Next Update Expected: Updates Temporarily on Hold
1.25 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 Central Zone 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?**
The indicator for this area of focus requires a district CDM strategy to be developed that will impact care across the continuum of care with a specific focus on primary health care and ambulatory care. In order to develop a strategy that will have impact, it requires:

1. Data collection to assess gaps
2. Asset Mapping
3. Buy-in of key stakeholders;
4. Development of strategy;
5. Implementation

Significant gains have been made on items 1, 2, 3, and 4. Implementation is not a deliverable for this fiscal time period as noted in the action plan. Based on the action plan, deliverables are on track for completion. There are no significant changes to the action plan at this time.

[Last updated: June 2014]
1.26 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 the Central Zone 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?
A baseline audit of 1000 discharge summary reports from April to September 2012 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%. For 2013/14, the same kind of audit showed a 60% compliance rate.

What are we doing about this?
Catherine Gaulton, VP of Performance Excellence, and Dr. Steven Soroka, VP of Medicine, are leading a steering committee to coordinate and guide the work already in progress. Its focus is on three initiatives: Safe Patient Information Transfer focusing on education and processes; implementation of an on-line eDischarge Report; and working with the IWK to improve transitions of care from the child-based to the adult-based health care system for individuals with chronic conditions. The group will continue to work through existing committees and structures (e.g. District Medical Advisory Committee, Grand Rounds, orientation, etc.) to embed quality transition practices across the organization. The results of the audit will be used to identify education opportunities and gaps. The eDischarge reporting tool will be implemented in all interested services.

There are no significant changes to the action plan at this time. [last updated June 2014]
1.27 Build a Culture of Customer Service

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

**Goal:** Patients, families and communities report customer service interactions with Central Zone 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 in the Central Zone. 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?

The graph below shows the 2012/13 baseline, 2013-14 results, as well as future targets. It should be noted that an error was discovered in the original baseline figures (February 2012 data were analyzed rather than February 2013 data). Accordingly, February 2013 data have been used to revise the baselines to 61.9% (Ambulatory) and 29.1% (Inpatient).

In 2013, 29.1% of respondents responded most favourably on inpatient surveys and 61.9% of respondents answered most favourably on ambulatory care surveys. These results are short of the 2013 targets and even slightly lower than the baseline results in 2012.

What are we doing about this?

There are three elements to the Build a culture of customer service action plan: 1) training and supports, 2) care redesign, and 3) sustaining and embedding the new culture.

The focus in 2013-14 has been on the first of these. A regular schedule of training accompanied by job aids, manager supports, communications and change management activities was launched in February 2014.

Initiatives for fiscal 2013-14 were implemented more or less according to plan; however we did not make concrete progress in training and supporting staff and in redesigning patient care experiences until the fourth quarter was not made and it was too late in the year to have an impact on the patient satisfaction survey data gathered in February. As well, the monthly volume of learners being trained in the Communicate with Heart ® program is approximately 50% of what is required to have full participation by September 2015.

With the slight decline in results from the baseline, in order to achieve the 2014-15 goal (10 point increase), there needs to be an overall increase of 16 to 16.7 points by March 31, 2015.

This slower than expected uptake of the training program coupled with the decline in patient-reported customer service means efforts have to be accelerated in 2014-15 and 2015-16.

The action plan will not require modification except to accelerate activities and achievement of process targets. In particular, there will be greater emphasis on the Patient Care Redesign initiative in 2014-15.

As planned, and in keeping with new developments in the field, it is proposed Central Zone’s definition of “quality” to encompass the three dimensions of Clinical Effectiveness, Safety, and Patient Experience be redefined. With this new perspective in place, capacity will be developed among Quality Teams to redesign patient experiences using Experience-Based Design (EBD) methodology.

A rapid, compressed version of EBD will be adopted. Quality Team efforts will be supported, monitored and reported on to complete redesign initiatives.

In short, the major change to the action plan is to leverage existing Quality & Safety resources and infrastructure using a faster version of the methodology to accelerate progress on this initiative.

[Last updated June 2014]
Percentage of Patients who Strongly Agree They Have been Treated with Courtesy and Respect in the Central Zone

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Graph Update Frequency: Yearly  
Graph Last Updated: Jan. 2015  
Next Update Expected: Summer 2015
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 Central Zone 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 Central Zone 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?**

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. The survey was not repeated in 2013/14 so a measure is not available.

**What are we doing about this?**

Considerable work has been done by the committee to identify target populations and approaches to support people in managing their own health. Survey data showed the population of young adults (age 18 - 34) relies heavily on web-based health information, so we have focused on the identification of topics appropriate for adaptive technologies (mobile and/or desktop) for this population. Pregnancy and early parenting have been identified as points of entry for young people who may not have had significant involvement with the health system until that point, and have identified (with provincial partners) a potential opportunity to leverage current work happening provincially. This may impact timelines and process, but there is no significant change to the action plan.

[Last updated June 2014]
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.

Why is it important?
This goal is about culture shift. Patients need to know 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?
The baseline results showed 77.8% of respondents agreed they or their family were consulted in making decisions about their care. The target was to increase this by one percentage point to 78.8% in 2013/14. The graph below shows the 2013/14 measure was 78.9%, thus the target was met.

What are we doing about this?
This priority area was able to achieve the targeted goals as the approach to ensuring success involved imbedding activities and practices in the day-to-day operations which collectively contributed to positively impacting on the question in the patient satisfaction survey. The question measures patient perception of involvement in their care decision making. It is specifically worded as: "Patients or their surrogates report that their involvement in decision-making related to their care met or exceeded their expectations."

There is no significant change in parameters of the action plan. The intent is to proceed with the systematic approach to implementing and integrating care planning practice across all clinical areas, continue to develop and implement unit-level criteria to inform and guide clinical teams involving patients and surrogates in care decisions, and develop related communication and education materials for clinical teams to outline why this work and approach is critical to our day-to-day delivery of care.

[Last updated July 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 Central Zone 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?**  
In 2012, 22% of 655 respondents indicated they were “very familiar” with the concept of appropriateness of care. See the graph below. No results are available for 2013/14.

**What are we doing about this?**  
The target for this goal focused on shifting public opinion and as such the original action plan identified the resources necessary to do that. The level of resources needed was beyond the capacity of the organization to meet. This goal area received no funding in year one to implement any of the initiatives identified in the original action plan. As a result, little-to-no progress was made on the action plan for this goal. It was decided by the action team in consultation with the executive sponsors that contracting a follow up survey was not a wise use of resources when there was little likelihood of seeing any change in the numbers.

Furthermore, the primary focus of the action plan shifted from the public to that of physicians. While communication efforts will be publicly targeted, shifting public awareness of appropriateness of care is now considered a secondary objective.

The action plan was revised in consultation with the executive sponsors. Communication efforts are now targeted at physicians and other health professionals. The Central Zone has committed to adopt and promote the Choosing Wisely Canada campaign as its primary vehicle to promote more appropriate care to physicians as well as patients. And finally, partnership and collaboration with other key stakeholders in this issue is a major focus—for example, working closely with Doctors Nova Scotia, Choosing Wisely Canada and Dalhousie Medical School's Value-Added Care Committee.

The goal statement and measures for this strategic goal need to change to reflect the move away from public awareness and the move towards provider awareness and actions. [last updated June 2014].
Respondents Who Were "Very Familiar" with the Concept of Appropriateness of Care

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Graph Update Frequency: Yearly  
Graph Last Updated: Jan. 2015  
Next Update Expected: Summer 2015
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 paying overtime which results in increased 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 in the Central Zone is shown below. The target is to have 6.15 or fewer per month. So far in 2015/16, the monthly average is 8.36 hours. This is higher than the target (unfavourable).

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 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, employees 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 in the Central Zone. In 2014/15, the percentage of overtime hours worked was 1.46%. This was a bit higher than the previous year but was still below the target of 1.89% (favourable). For April–September 2015, the rate was also below target.

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 the 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.
- Managers review a newly developed monthly overtime report to monitor overtime in a more timely fashion.

[Last updated August 2014]
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 Central Zone, 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 Central Zone 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 Central Zone 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 the Central Zone 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 the Central Zone and our larger community.
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 Central Zone 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 the Central Zone 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 Central Zone management and engagement with Central Zone 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 in the Central Zone. 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 Central Zone Physician Survey

Frequency Tracked: Every two years  Last Updated: June 2011  Next Update Expected: 2014

Central Zone’s Strategic Indicators Report, October 23, 2015
3.6 Improve Leadership Capacity at all Levels

**Strategy**: Transformational Leadership  
**Goal**: Employees and physicians working in the Central Zone will meet or exceed expectations of leadership in their work as defined by the Central Zone 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?**
In the 2013/14 leadership survey, the following percentages of respondents indicated 4.5 or higher out of 5 in each of the three dimensions:

- **Clear Expectations**: 13% (same as baseline; short of target)  
- **Transformational Leadership** (formal leaders only): 23% (improvement over baseline; short of target)  
- **Leading in Own Work**: 28% (improvement over baseline; short of target)

All baselines, measures, and targets can be seen in the graph below.

**What are we doing about this?**
The provincial health system in Nova Scotia is moving towards a common approach to guide leadership development based on LEADS in a Caring Environment, so there has been a proactive switch to LEADS as the organizing model for leadership development in the Central Zone. The team will continue to create internal mechanisms (assessment tools, education, online learning resources, and coaching) to assess and continue to develop leadership capacity and will be launching an orientation to LEADS in the fall.

Despite the array of education and learning supports available and regular communication of leadership expectations to formal leaders, the 2013/14 goal was not met. To change behaviour and get the results the organization expects, evidence indicates focusing on structure, support, and accountability. There is sufficient support available but it appears that accountability is low. Individual leaders, in collaboration with their supervisors, are responsible for their own development and delivering on these expectations, with the help of Central Zone’s available resources. Formal leaders (including physicians) must model the behaviours, monitor how their team members are demonstrating them, and performance manage those who do not comply. The action team plans to remind senior leaders of these basic steps and to create ways to acknowledge and recognize leadership in action on the job and offer guidance in coaching those who have competence gaps.

There are no major changes to the leadership capacity action plan, although the process to merge the district health authorities may require unanticipated adjustments. As well, in continuing efforts to fully integrate supports for physicians and administrative management staff, work will be done with Dalhousie’s Faculty of Medicine to ensure their new career development software includes relevant Central Zone leadership development information and themes.

[Last updated: June 2014]
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.

**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 Central Zone, 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?**

In the 2012/13 employee and physician survey, 35% of respondents indicated a response of 4.5 or higher out of 5.0 with regard to accountability. In 2013/14, this percentage dropped to 29%. Details can be seen in the graph below. As a subgroup, physicians were at 31% for both 2012/13 and 2013/14.

The following trends were noted:

- A sharp increase in the accountability factors for directors
- Some positive change for supervisor and clerical employees
- No appreciable change for Health Services Managers
- Some decline for Confidential Excluded employees and Other Managers
- A marked decline for other clinical staff (nursing and allied health professionals) and support staff.

There is some sense that the decline for a number of these employees was connected to the high profile labour issues and subsequent work stoppages, which occurred around the time the survey was conducted.

**What are we doing about this?**

The anticipated first year increase was expected to occur and coincide with the development of AFP Deliverables work (accountability) however the original timelines were detailed. A big swing in the numbers for 2014-15 is anticipated which should have this back on track as the deliverable will be finalized by September 1, 2014. At the same time, specific work focusing on resident accountability will be launching which will mean all facets of the action plan will be in motion.

Work is being done on developing and rolling out accountability measures for management and in turn this should increase the accountability factors for other staff. The work on job profiles, competencies and skills for health services managers has been completed and that work is being used to influence the development of accountability frameworks, and training for this group. There is also work being done to introduce an accountability framework for new hires.

With the impending provincial consolidation, the initial scope of the work on Accountability has been scaled back due to resource constraints but the Project Plan has been revised to take that into account.

With the aforementioned efforts in progress, it is expected the three-year target for this work will be met.

[last updated June 2014]
Employees & Physicians With a Response of 4.5 or Greater (Out of 5) on Survey Items Relating to Self-Reported Accountability

Graph Update Frequency: Yearly  
Graph Last Updated: Jan. 2015  
Next Update Expected: Summer 2015
4  Innovating Health and Learning

4.1 Research Funds from Grants & Contracts

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

Why is it important?
Central Zone Research Services manages more than 1,200 research accounts (funded projects) supporting 1487 active research projects (funded and unfunded), and is responsible to ensure that all legal, financial and ethical requirements and approvals for research in the Central Zone are fulfilled. There are 280 research employees who are integral members of the interdisciplinary healthcare teams providing quality patient-centered care in the Central Zone.

How are we doing?
Total research funds broken down into grants and contracts are shown in the graph below. The increase in grant funding is attributed to several new large investigator-initiated projects one of which is the SPOR initiative funded by Canadian Institutes for Health Research, Nova Scotia Health Research Foundation, and Nova Scotia Department of Health and Wellness. Click here for more information.

What are we doing about this?
Central Zone 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.

<table>
<thead>
<tr>
<th>Year</th>
<th>Grants</th>
<th>Contracts</th>
<th>Total</th>
</tr>
</thead>
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<tr>
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<tr>
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</tbody>
</table>

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, this is still in the early stages 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 in the Central Zone; second, translating innovations into improvements in care and services.

**How are we doing?**  
There was no interim target for this goal.

**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

The attainment of this year’s goal is directly related to having a Health Technology assessment capability the Central Zone and that is in turn directly related to conversations provincially on health technology assessment. This continues to be pursued provincially and with health transition leadership.

[Last updated: August 2014]
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.

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**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 in the Central Zone.

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?**

Baseline results: In the partner survey, respondents rated the quality of our partnership with regard to both research and education at 66%. Results from a follow-up survey are not available.

**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 the Central Zone.

[Last updated August 2013. An update for 2013/14 was not provided]
### 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

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#### What is being measured?

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

The number of hours has been chosen as the measure for interprofessional education, and the percentage of new, Research Ethics Board-approved interprofessional initiatives as the 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?

The 2013/14 target was met for interprofessional education. Results for interprofessional research were not provided.

#### What are we doing about this?

We intend to sustain the levels of IP education through focusing on skills-building sessions on IP Facilitation. This year we have targeted clinical and corporate employees who regularly deliver education. We hope to extend this skills building to less developed areas in the future, i.e., Medical Education. Work is being conducted on targeting clinical teams to work with to advance interprofessional collaboration. We intend to sustain current levels and expand IPE student placements by the continued engagement of staff and physicians in new clinical areas. We have recruited Stephen Phillips to co-lead the student IPE placement stream so to better model interprofessional practice but also to enhance engagement of physicians and their students both in the Central Zone and at Dalhousie School of Medicine. In addition, we are creating a resource hub for knowledge transfer and hosting an annual interprofessional day targeted at front-line staff. These have been areas of focus and we believe they support sustaining the amount of interprofessional education. We are waiting to partner with colleagues provincially on interprofessional simulation opportunities. We are hopeful this work will proceed in the coming year.

[Last updated July 2014. An update was not provided for the research portion of the goal]
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?

The measure is the percentage of typical cases for which the average length of stay (ALOS) is less than the expected length of stay (ELOS). ALOS is the average length of stay for patients in a particular case mix group (CMG). ELOS is how long patients in that CMG would be expected to stay in hospital. The ELOS is derived from national data.

The main focus will be on three CMGs: heart failure without coronary angiogram, chronic obstructive pulmonary disease (COPD), and ischemic event of the central nervous system (CNS) (but not to the exclusion of other CMGs).

### Why is it important?

These 3 CMGs are in the top 10 CMGs by volume. If these three CMGs are addressed, there will be improvement in the overall results and results in these areas influence other key indicators being tracked. Delays in discharging patients in these CMGs affect the whole system—right back ED patients waiting for a bed.

### How are we doing?

For 2014/15, for the three CMGs combined, the proportion of typical cases with an ALOS equal to or less than the ELOS was 53.2%. See the graph below. This is an increase from the 2012/13 baseline and the previous year, but falls short of the 2014/15 target of 55%. Individual CMG percentages were:

- Heart failure without coronary angiogram: 52% (surpassed target of 49%)
- COPD: 57.1% (did not meet target of 58%)
- Ischemic event of the CNS: 44% (did not meet target of 51%)

For Q1 of 2015/16, the rate for all three CMGs combined was 40.5%—short of the target of 60%.

### What are we doing about this?

Continued work related to integrating robust utilization management activities and practices at the unit level will assist to move this priority area towards identified targets. Work is ongoing at the unit level related to BUMP, patient room white boards, and standardized discharge planning processes. It is important to note that for two of the indicators, over the course of the last 12 months, there has been an increase in cases translating to an increase in service volume which may have contributed to not reaching the goals. For “ischemic event of the CNS”, there was an increase in 50 cases from 2012/13 to 2013/14. For “COPD”, there was an increase of 11 cases and for “heart failure without coronary angiogram”, the volumes remained stable at 307 cases. The volume and complexity of these patients is a variable in a team’s ability to achieve targets related to expedient discharge.

The activity areas identified to support the achievement of targets remain valid and will be pursued at the unit and system level: the utilization management practices, design, development, and implementation of a district clinical service plan and master facilities plan.

[Last updated: June 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. There was no target for 2013/14.

**What are we doing about this?**
LET provided the mandate for the work on case costing activity to continue, as such great progress is being made on the case-costing front. As follow-up to the fourth quarter OPIA status report, two case-costing pilot groups have been selected—one from surgery and one from medicine. The pilot groups continue to meet with physicians/clinical leaders, leveraging the case costing data to understand opportunities for planning and service delivery. Much of the pilot work is focus on understanding the costing data and reporting.

With respect to the 14 Our Promise in Action (OPIA) areas of focus and action plans, the $700,000 of OPIA funding allocated in the fourth quarter of fiscal 2013/2014 has been approved and annualized in the fiscal 2014/2015 business plan and budget. As a result, approximately $1.5M–$2M has been allocated towards OPIA action plans in the 2014/15 fiscal year’s budget.

[Last updated August 2014]
5.3 Be Better Environmental Stewards

**Strategy:** Sustainability

**Goal:** The Central Zone 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.

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**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 usage (in kWh)—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?**

From July 2012 to March 31, 2014, we have achieved a measured savings of 4,870,992 kWh/year (a 5.8% decrease), which exceeds the 5% decrease goal of 4,191,550 kWh/year. See the graph below for baseline, actual and target measures.

**What are we doing about this?**

The projects that contributed to this reduction included recommissioning of the Rehab building steam plant boiler control, and various lighting retrofits across the district. It is important to state that this reduction is actually a cost avoidance. As the organization changes and new equipment gets added and/or processes are changed, the district’s actual usage of electricity increases. This work to reduce usage helps us offset some of that increase.

As of July 2, 2014, the partnership with Efficiency Nova Scotia (ENS) has been renewed and David Bligh has been the onsite energy manager since January 1, 2014. Central Zone pays 50% of David’s salary and ENS recovers their 50% share from rebates Central Zone earns from projects. Unfortunately, there is not a confirmed funding source for the 2014/15 fiscal year. Without this, the 2014/15 further 5% reduction goal will not be achieved and the partnership with ENS will end for the onsite energy manager as there will not be any projects for him to lead.

[Last updated July 2014]
5.4 Implementation of the Electronic Health Record

**Strategy:** Sustainability
**Goal:** An electronic health record.
**Measure:** Percentage of the implementation of the Electronic Health Record.

What is being measured?
A fully integrated electronic health record (EHR) is a real-time, patient-centered record that makes information available instantly and securely to authorized users. EHRs are designed to contain and share information from all providers involved in a patient’s care journey. Key EHR components include: electronic clinical documentation; Positive Patient Identification; Computerized Physician Order Entry.

Why is it important?
Connecting people and their health information electronically is essential to provide real time access to health information. We have heard from patients, and staff, how essential this is to transforming health and health care. Integrated patient information management solutions such as the EHR are critical to supporting a systemic shift in health care, from that of the organizational view of patient health to patient ownership of his/her own health. Implementation of the EHR has been identified as a priority in Central Zone’s Business Plans and Strategic Plan, and aligns with the long term goals for provincial clinical services of the Department of Health & Wellness.

How are we doing?
Central Zone’s efforts to implement an EHR have stalled due to the province’s desire to have a single health information solution. The province is commencing with the development of a business case for treasury board to move all clinical system applications to a single solution, from today’s three information technology platforms (Central Zone – Best of Breed, IWK – Meditech Magic, All Other Districts – Meditech). Central Zone’s E.H.R. initiative (RFP for technology) has been put on hold as a result of this provincial initiative. However, the province has approved Central Zone to launch preparatory work (change management, form consolidation, electronic form development, business process, etc.). We are recruiting a team of new resources to lead this work.

What are we doing about this?
We realize that implementing a fully electronic health record involves much more than just installing a software system. We are currently undertaking activities that will support the introduction of an electronic records system once it is chosen. Infrastructure such as computer terminals and wireless connects must be in place. Process redesign and change management needs for the front lines and support areas must be explored to ensure we make the most of any system.

[Last updated: July 2014]
5.5 Actual Expenditure to Approved Budget

**Strategy:** Sustainability  
**Goal:** Be good fiscal stewards  
**Measure:** Percentage variance of actual expenditure to approved budget

**What is being measured?**
Actual expenditure to approved budget measures our fiscal accountability. Financial reporting is intended to provide clients, stakeholders, citizens, and taxpayers with a general overview of the Central Zone's finances and to demonstrate accountability for the tax funding it receives.

**Why is it important?**
Central Zone understands the financial pressures our provincial government and Nova Scotia taxpayers are facing. A new approach is needed. The reality of our finite funds means we must find ways to make the most of the limited human and financial resources with which we are entrusted. Our financial plans reflect a commitment to responsible stewardship of public resources, supporting our citizens to improve overall. Accountability means taking responsibility for our words and actions in open and transparent ways. It encompasses sustainability by changing the way we think about our resources, whether they be people or buildings, dollars and cents, or earth and air.

**How are we doing?**
The table below shows total budgeted, actual, and variance for Central Zone revenue and expenses in 2013/14. Actual expenditure showed a variance of 0.44% over the approved budget.

<table>
<thead>
<tr>
<th>Fiscal Year 2013-2014</th>
<th>Budget</th>
<th>Actual</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue</td>
<td>$865,822,800</td>
<td>$869,574,109</td>
<td>$3,751,308</td>
<td>0.43%</td>
</tr>
<tr>
<td>Partners for Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Net Revenue)</td>
<td>$95,445</td>
<td>$95,445</td>
<td></td>
<td>n/a</td>
</tr>
<tr>
<td>Expenses</td>
<td>$865,822,800</td>
<td>$869,669,553</td>
<td>($3,846,753)</td>
<td>(0.44%)</td>
</tr>
<tr>
<td>Net Result</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

Budget & Planning coordinates the annual business plan submission to the Department of Health and Wellness. Ongoing 2013/2014 financial reporting & oversight was provided to the sustainability committee of the board, as well to the board on significant financial pressures and risks. The most significant financial pressure for the 2013/2014 fiscal year centered on the utilities budget. Contributing factors included the ongoing natural gas price escalation and the harsh winter climate. Overall the utilities costs exceeded budget by just under $5M. A balanced budget was achieved through internal mitigation strategies and one-time funding of $2.2 million from Department of Health & Wellness to help offset utility costs.

**What are we doing about this?**
In addition to the provision of fiscal oversight to the sustainability committee & the board, Central Zone provides regular financial updates to the Department of Health & Wellness (DHW). While the demand for health care services continues to grow, we are actively pursuing opportunities to reduce costs through improved scheduling, service delivery and purchasing processes. This work will continue within the organization and in collaboration with other district health authorities and provincial partners.

[last updated July 2014]
5.6 Focus on Sustainability

Strategy: Sustainability
Goal: Appropriate level of funding requests for capital equipment
Measure: Percentage of funded requests for capital purchases in relation to identified required funding

What is being measured?
The measure for this goal is the percentage of funded requests for capital purchases in relation to identified required funding.

Why is it important?
To fulfill this goal, we need to ensure we prioritize our requests for capital funding and provide clear, compelling business cases to ensure funders are aware of the need, risks and impacts for each request.

A new process was introduced to evaluate and prioritize all requests for capital equipment.

We are pursuing 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.

How are we doing?
The graphs below show the progress toward this goal. The first graph shows progress toward obtaining capital funding for identified priority purchases and infrastructure improvements. The second graph shows the percentage of actual funding approval compared to the target.

What are we doing about this?
Infrastructure. Requests are submitted to DHW in categories: funding for design work; repair and renewals(R&R) over $90,000 and R&R under $90,000. There is a separate submission for capital projects over $1 Million; clinical capital projects would fall in this as well. In 13/14 we had approved funding from internal and external sources of $10,355,029 for 4 projects. We currently have business cases submitted for projects for fiscal 14/15; 15/16 e.g. next phase of the Innovative Care Flexible Facilities Renewal; Purdy Exit.

We have allocated funds for our on-site energy advisor and projects. This is to help us reach our business plan target of reduction in electrical consumption by 15% over 3 years.

Clinical Equipment. Ways to improve our capital funding are continuously being sought. Central Zone participated in a DHW consulting project and our primary recommendation was that the funding model for equipment should span more than one year to enable us to access items in a more stable manner and complete projects. Clinical Engineering continues to maximize the usable lifespan of the equipment. In February 2014, DHW requested a business case for the three Linear Accelerators ($12M) on our list. It was submitted by Central Zone in April. This was outside the normal process due to the high cost of items. There is continuous work with Directors and Managers to find any available sources to cover urgent needs. Due to financial constraints, a proactive multi-year asset management plan for equipment replacement is not feasible at this time. With limited funds we rank the urgent needs and purchase what we can within funding sources.

Equipment (not direct patient care). A need has been noted in our next Capital Budget (FY14/15) to try to allocate funds for this category and rank them separately. These types of requests previously were ranked with the clinical equipment and would never rank high enough to receive funding. If the equipment is substantial, we can also submit it to DHW, although it is difficult to obtain funding through that process.

In summary, while we all work to secure capital funding, as a system it is an on-going challenge.

[Last updated June 2014]
5.7 Improve Population Health

**Strategy:** Sustainability

**Goal:** Influence change in six major public policies that affect population health

**Measure:** Active participation in and contribution to development of primarily non-health sectors

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**What is being measured?**
Central Zone’s active participation in and contribution to development of healthy public policy by primarily non-health sectors (municipality, school board, finance sector, community services sector, etc). The Our Promise in Action 2013 – 2016 goal is to influence two major policies per year in each of 2013/14, 2014/15, and 2015/16. At least one policy should be at the municipal government level. A major policy is one that actively engages the senior leadership of the target sector and that could lead to significant public dialogue. Policies need not be new if Central Zone’s active involvement continues from one year to the next, as policies sometimes take years to develop.

**Why is it important?**
The Pepin and Keon report on Population Health (Senate Sub Committee report on Population Health, 2009) describes that much of what influences health exists in policies and arenas well outside of health care (1). While most authorities agree that a maximum of 25% of health is achieved through health service delivery and related policies, the Pepin/Keon report points out that 10% of health is achieved through creation of policies promoting healthy built environments, with another 50% being contributed to by social and economic policies. Advocating for and contributing to non-health sector led healthy public policies is therefore the most important strategy we can use to act on the determinants of health and reduce health disparities.

**How are we doing?**
In 2013-14, Central Zone actively contributed to the policies noted in the table below. Anticipated policy directions for 2014/15 and 2015/16 are also noted.

**What are we doing about this?**
Gaynor Watson-Creed, Medical Officer of Health, and Barbara Hall, Vice-President, Person-Centred Health, are overseeing activities to achieve the 2016 goal.

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<table>
<thead>
<tr>
<th>Focus of Policy Direction</th>
<th>2013/14</th>
<th>2014/15 (anticipated)</th>
<th>2015/16 (anticipated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Municipal Government Local, i.e., school board, Health Zone, CHB</td>
<td>Central Zone Breast Feeding Policy (complete)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Municipal Government</td>
<td>Municipal Alcohol Strategy, HRM (first draft complete)</td>
<td>Guidelines for the development of prostitution business districts (HRM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HRM Regional Municipal Planning Strategy (complete)</td>
<td>Healthy Eating in Recreation Centres (HRM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mayor’s Round Table on Health (HRM) (initiated)</td>
<td>Finalization of Complete Streets Policy (HRM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mayor’s Round Table on Housing (HRM) (initiated)</td>
<td>Contribution to Municipal Food Strategy (HRM)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contribution to HRM Centre Plan (HRM)</td>
<td></td>
</tr>
<tr>
<td>Provincial or Federal</td>
<td>Guidelines for the development of prostitution business districts (Provincial, led by Dept Community Services and DHW)</td>
<td>Healthy Eating in Recreation Centres (HRM) (Provincial, led by DHW)</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix A: Patient Safety Scorecards

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</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>
<th>Q1 14/15</th>
<th>Q2 14/15</th>
<th>Q3 14/15</th>
<th>Q4 14/15</th>
<th>Q1 15/16</th>
<th>Q2 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Hospital Acquired Infections</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MRSA Incidence (per 10,000 patient days)</td>
<td>&lt; 11</td>
<td>5.6</td>
<td>6.4</td>
<td>7.1</td>
<td>5.7</td>
<td>4.5</td>
<td>4.9</td>
<td>6.3</td>
<td>6.1</td>
<td>4.7</td>
<td>6.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. difficile Incidence (per 10,000 patient days)</td>
<td>&lt; 6.0</td>
<td>3.0</td>
<td>3.9</td>
<td>5.0</td>
<td>3.4</td>
<td>2.9</td>
<td>2.9</td>
<td>2.7</td>
<td>3.7</td>
<td>2.7</td>
<td>3.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>VRE Incidence (per 10,000 patient days)</td>
<td>&lt; 8.6</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>
<td>0.0</td>
<td>0.3</td>
<td>0.1</td>
<td>0.3</td>
<td>0.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DGH Quick Response Team</strong></td>
<td></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>
<td>1.0</td>
<td>3.3</td>
<td>3.0</td>
<td>3.0</td>
<td>0.3</td>
<td></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>2014</th>
<th>2015 Jan-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Hand Hygiene Compliance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Before Patient Contact</td>
<td>80%</td>
<td>29%</td>
<td>54%</td>
<td>46%</td>
<td>60%</td>
<td>65%</td>
<td>68%</td>
</tr>
<tr>
<td></td>
<td>After Patient Contact</td>
<td>80%</td>
<td>55%</td>
<td>75%</td>
<td>74%</td>
<td>81%</td>
<td>84%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>Overall</td>
<td>80%</td>
<td>44%</td>
<td>66%</td>
<td>61%</td>
<td>72%</td>
<td>76%</td>
<td>79%</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>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Mortality</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Standardized Mortality Ratio (HSMR)</td>
<td>≤ 100</td>
<td>105*</td>
<td>99</td>
<td>107</td>
<td>98</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Patient Safety Culture Survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Excellent&quot; &amp; &quot;Very Good&quot; Responses</td>
<td></td>
<td>47%</td>
<td></td>
<td>51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Acceptable&quot; Responses</td>
<td></td>
<td>44%</td>
<td></td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Poor&quot; and &quot;Failing&quot; Responses</td>
<td></td>
<td>10%</td>
<td></td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of &quot;Excellent&quot;, &quot;Very Good&quot;, and &quot;Acceptable&quot; Responses Combined</td>
<td></td>
<td>90%</td>
<td>91%</td>
<td>92%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Annual Patient Safety Training</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage Who Completed at Least One Patient Safety Course</td>
<td>100%</td>
<td>54%</td>
<td>51%</td>
<td>63%</td>
<td>75%</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td><strong>Patient Experience Survey – Concern for Safety: Inpatient &amp; Organizational Results</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of &quot;Agree&quot; responses to: Staff consistently washed hands before providing care</td>
<td></td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
<td>89%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of &quot;Agree&quot; responses to: Before giving medications, did staff tell you what the medicine was for?</td>
<td></td>
<td></td>
<td>90%</td>
<td>87%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td></td>
<td>Percentage of &quot;Agree&quot; responses to: Hospital staff described possible side effects in a way that was understandable</td>
<td></td>
<td>90%</td>
<td>69%</td>
<td>69%</td>
<td>67%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percentage of &quot;Yes&quot; responses to: Told what you could do to make sure you were safe in hospital</td>
<td></td>
<td>90%</td>
<td>69%</td>
<td>68%</td>
<td>69%</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 of 100.*
## Appendix B: Access Score Card (Wait Times)

<table>
<thead>
<tr>
<th>Treatment / Procedure</th>
<th>Target Wait Time</th>
<th>Average Wait Times for August 2015 (except where otherwise noted)</th>
<th>Location</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Computed Tomography (CT)</td>
<td>28 days</td>
<td>Central Zone</td>
<td>24 days</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>28 days</td>
<td>QEII</td>
<td>173 days</td>
<td>Not meeting target</td>
</tr>
<tr>
<td>Radiotherapy – Intermediate Cases</td>
<td>14 days</td>
<td>QEII</td>
<td>20 days</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Radiotherapy – Urgent Cases</td>
<td>7 days</td>
<td>QEII</td>
<td>8 days</td>
<td>Meeting target</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Central Zone</td>
<td>66% of cases completed within target (Q1 2015/16)</td>
<td>Almost meeting target</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Central Zone</td>
<td>31% of cases completed within target (Q1 2015/16)</td>
<td>Almost meeting target</td>
</tr>
<tr>
<td>Hip Fracture Repair</td>
<td>100% of cases completed within 48 hours</td>
<td>Central Zone</td>
<td>82% of cases completed within target (Q1 2015/16)</td>
<td>Almost meeting target</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>100% of cases completed within 16 weeks</td>
<td>Central Zone</td>
<td>73% of cases completed within target (Q1 2015/16)</td>
<td>Meeting target</td>
</tr>
<tr>
<td>CABG – Urgent Cases</td>
<td>7 days</td>
<td>QEII</td>
<td>39 days (median wait time)</td>
<td>Meeting target</td>
</tr>
<tr>
<td>CABG – Semi-Urgent Cases</td>
<td>21 days</td>
<td>QEII</td>
<td>40 days (median wait time)</td>
<td>Meeting target</td>
</tr>
<tr>
<td>CABG – Scheduled Cases</td>
<td>42 days</td>
<td>QEII</td>
<td>22 days (median wait time)</td>
<td>Meeting target</td>
</tr>
<tr>
<td>ED – 90th Percentile Wait Time from Triage to Admission</td>
<td>8 hours</td>
<td>QEII</td>
<td>22 hours (90th percentile)</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DGH</td>
<td>40 hours (90th percentile)</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>QEII</td>
<td>142 minutes</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>DGH</td>
<td>165 minutes</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCHC</td>
<td>85 minutes</td>
<td>Meeting target</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCH</td>
<td>67 minutes</td>
<td>Meeting target</td>
</tr>
</tbody>
</table>
## Appendix C: Summary of the 14 Areas of Focus with Respect to the 2013/14 Targets

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>2013/14 Interim Annual Target</th>
<th>Actual Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRANSFORMING PERSON-CENTRED HEALTH CARE EXPERIENCE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthen community-based care for chronic disease.</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Improve quality of care in transitions.</td>
<td>25%</td>
<td>60%</td>
</tr>
<tr>
<td>Build a culture of customer service.</td>
<td>↑ 5%</td>
<td>↓ 1%</td>
</tr>
<tr>
<td><strong>CITIZEN AND STAKEHOLDER ENGAGEMENT AND ACCOUNTABILITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner with the public so they can play a key role in managing their own health.</td>
<td>↔ 0 pt</td>
<td>↔ 0 pt</td>
</tr>
<tr>
<td>Involve patients directly in their care.</td>
<td>↑ 1 pt</td>
<td>↑ 1 pt</td>
</tr>
<tr>
<td>Lead dialogue with the public addressing appropriateness of care.</td>
<td>↑ 4 pt</td>
<td>–</td>
</tr>
<tr>
<td><strong>TRANSFORMATIONAL LEADERSHIP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve leadership capacity at all levels.</td>
<td>↑ 5 pt</td>
<td>↑ 2 pt</td>
</tr>
<tr>
<td>Strengthen accountability of employees and physicians.</td>
<td>↑ 5 pt</td>
<td>↓ 6 pt</td>
</tr>
<tr>
<td><strong>INNOVATING HEALTH AND LEARNING</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focus on innovation that has benefits for patients and aligns with our mission.</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Strengthen partnerships with learning institutions.</td>
<td>66%</td>
<td>–</td>
</tr>
<tr>
<td>Build our capacity for interprofessional research and interprofessional education.</td>
<td>↑ 10 pt</td>
<td>↑ 10 pt</td>
</tr>
<tr>
<td><strong>SUSTAINABILITY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Innovate systems and processes for greater efficiency and quality.</td>
<td>52%</td>
<td>48%</td>
</tr>
<tr>
<td>Develop funding models based on our priorities.</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Be better environmental stewards.</td>
<td>↓ 5%</td>
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</tr>
</tbody>
</table>
Appendix D: Strategic Streams

This report has been organized around Central Zone’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** - Central Zone 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** - Central Zone 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 E: 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 in the Central Zone. The framework is not a standalone document – it is supported by Our Promise, Our Declaration of Health, the Patient Safety Plan, our Strategic Indicators Reporting Framework, Central Zone 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 the Central Zone.

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 the Central Zone’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 F: Our Promise in Action Poster
Appendix G: Contributors

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

- Gail Blackmore, Senior Director, Quality Improvement, Safety, and Patient Relations
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- Sara Brown, People Services
- Pam Currie, Professional Practice
- Susan Delaney, Diagnostic Imaging
- Lisa Dillman, Decision Support
- Joanne Dunnington, Perioperative Services, Pain Services, Regional Tissue Bank
- Ruth Harding, Performance Excellence Program
- Denise Hatchette, Finance
- Margaret Ivey, Heart Health & Critical Health
- Nancy MacDonald, Decision Support
- Tammy MacDonald, Infection Control
- Joel Maxwell, Performance Excellence Program
- Lynn Molloy, Department of Surgery
- Amanda Murphy, Decision Support
- Kim Ryan, Performance Excellence Program
- Stacey Squires, Perioperative Nursing
- Sarah Teal, People Services
- Jodie Trembley, Cancer Care Program

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