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. A summary of indicators related to patient safety can be found in Appendix A and a summary of indicators related to access (wait times) can be found in Appendix B. Appendix C will provide a summary of the progress of the 14 Areas of Focus when progress measures become available.

- Checkmark: Meeting target or on track to meet target
- Arrow: Trending toward target
- Red X: Not meeting or will not meet target
- Blue B: Baseline measure only
- Delta: Caution – needs work to meet target
- Diagonal chevron: Being tracked but with no established target or standard.

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

<table>
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<th>Target</th>
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<tr>
<td></td>
<td><strong>Transforming Person-Centred Health Care Experience</strong></td>
<td></td>
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<tr>
<td></td>
<td><strong>Access Indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✔</td>
<td>Surgery Cancellation Rates</td>
<td>Has not met the target since December 2012.</td>
<td>8</td>
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<td>✔</td>
<td>Wait Times – Elective CT</td>
<td>Has been meeting the target since December 2012, except for in July 2013 when the wait time was only one day longer than the target.</td>
<td>10</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – Elective MRI</td>
<td>In July 2013, the wait time was over seven times longer than the target of 28 days. There has been a slow trend of improvement over the past year.</td>
<td>10</td>
</tr>
<tr>
<td>✔ ✔</td>
<td>Wait Times - Radiotherapy Treatment</td>
<td>Meeting target for urgent cases but not for intermediate cases.</td>
<td>12</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – Hip Fracture Surgery</td>
<td>Not meeting the target for Q1 2013/14.</td>
<td>14</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – Hip Replacement</td>
<td>Not meeting the target for Q1 2013/14.</td>
<td>15</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – Knee Replacement</td>
<td>Not meeting the target for Q1 2013/14.</td>
<td>16</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – Cataract Surgery</td>
<td>Not meeting target. Little change over the past three years.</td>
<td>17</td>
</tr>
<tr>
<td>✔ ✔ ✔</td>
<td>Wait Times – Open Heart Surgery</td>
<td>Meeting target for scheduled and urgent cases. Not meeting the target for semi-urgent cases.</td>
<td>17</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 target of 8 hours for the 90th percentile wait time.</td>
<td>19</td>
</tr>
<tr>
<td>✖</td>
<td>Wait Times – From Triage to Physician in the Emergency Department</td>
<td>None of the four sites is meeting the target of 30 minutes.</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td><strong>Patient Safety Indicators</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✔</td>
<td>Transmission Rates – MRSA</td>
<td>The rates at CDHA are far below the 2009 national rate.</td>
<td>21</td>
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</table>
## Capital Health’s Strategic Indicators Report, October 11, 2013

<table>
<thead>
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<th>Status / Comment</th>
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<tr>
<td>✔️</td>
<td>Incidence Rate – VRE</td>
<td>The rates at CDHA are far below the 2009 national rate.</td>
<td>21</td>
</tr>
<tr>
<td>✔️</td>
<td>Infection Rate – C. difficile</td>
<td>The rates at CDHA are below the 2011 national rate.</td>
<td>23</td>
</tr>
<tr>
<td>🟢❌</td>
<td>Hand Hygiene Compliance</td>
<td>In Apr-Jun, the after patient/patient environment contact rate was 82%—better than the NS target of 80%. The “before” rate was below target at 62%.</td>
<td>24</td>
</tr>
<tr>
<td>❌</td>
<td>Hospital Standardized Mortality Ratio</td>
<td>The overall CDHA rate for 2012/13 is higher (worse) than the national average from 2009/10.</td>
<td>25</td>
</tr>
<tr>
<td>✔️❌</td>
<td>Patient Experience Survey</td>
<td>In 2012/13, the positive response target of 90% was exceeded in five out of eight dimensions.</td>
<td>26</td>
</tr>
<tr>
<td>🟢</td>
<td>Patient Safety Culture</td>
<td>No target set. The 2012 survey shows improvement over 2010.</td>
<td>27</td>
</tr>
<tr>
<td>❡</td>
<td>Completion of Patient Safety Training</td>
<td>For April–July 2013, 19% have completed at least one patient safety training course. More training will have to be completed to meet the annual 2013/14 target of 100% completion.</td>
<td>28</td>
</tr>
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### Additional Transforming Person-Centred Health Care Experience Indicators

<table>
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<tr>
<td>❡</td>
<td>Length of Stay – Number of Conservable Days</td>
<td>Using data from the first several months of 2013/14 to estimate conservable days for the full fiscal year makes it look as if the target will not be met.</td>
<td>29</td>
</tr>
<tr>
<td>✔️</td>
<td>Occupancy Rates</td>
<td>For Apr-Aug of 2013/14, the DGH occupancy rate was above the target of 90% (unfavourable), but the rate for the QEII was just below the target (89.9%).</td>
<td>30</td>
</tr>
<tr>
<td>✔️</td>
<td>Emergency Department – Left Without Being Seen</td>
<td>No sites are meeting the target of 2% or less. The exception is Hants where only 0.9% left without being seen in August 2013.</td>
<td>32</td>
</tr>
<tr>
<td>❥</td>
<td>Long Term Care – Patients Placed &amp; Waiting to be Placed</td>
<td>Above target of 75 patients waiting to be placed.</td>
<td>33</td>
</tr>
<tr>
<td>🟢</td>
<td>Strengthen Community-Based Care for Chronic Disease</td>
<td>Baseline measurement only at this time</td>
<td>35</td>
</tr>
<tr>
<td>🟢</td>
<td>Improve Quality of Care in Transitions</td>
<td>Baseline measurement only at this time</td>
<td>36</td>
</tr>
<tr>
<td>🟢</td>
<td>Build a Culture of Customer Service</td>
<td>Baseline measurement only at this time</td>
<td>37</td>
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### Citizen and Stakeholder Engagement and Accountability

<table>
<thead>
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<tr>
<td>🟢</td>
<td>Partner with the Public so Individuals and Communities can Play a Key Role in Managing Their Own Health</td>
<td>Baseline measurement only at this time</td>
<td>38</td>
</tr>
<tr>
<td>🟢</td>
<td>Involve Patients Directly in Their Care</td>
<td>Baseline measurement only at this time</td>
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<td>Target</td>
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<tr>
<td>--------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>B</td>
<td>Lead Dialogue with the Public</td>
<td>Baseline measurement only at this time</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>Addressing Appropriateness of Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Absenteeism</td>
<td>Improvement can be seen for May-Aug 2013, but still short of the target.</td>
<td>41</td>
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<tr>
<td>B</td>
<td>Overtime</td>
<td>Met the target in 2012/13 and continues to remain below target for April to August 2013, although there has been some increase over the last two fiscal years.</td>
<td>42</td>
</tr>
<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>43</td>
</tr>
<tr>
<td></td>
<td>Employee Survey – Accreditation</td>
<td>Employee ratings of ‘job satisfaction’ and ‘clarity about expectations’ remained high for 2012. However, there were slight increases in the number of ‘unfavourable’ responses in almost all dimensions</td>
<td>44</td>
</tr>
<tr>
<td>B</td>
<td>Improve Leadership Capacity at all Levels</td>
<td>Baseline measurement only at this time</td>
<td>46</td>
</tr>
<tr>
<td>B</td>
<td>Strengthen Accountability of Employees and Physicians.</td>
<td>Baseline measurement only at this time</td>
<td>47</td>
</tr>
<tr>
<td>B</td>
<td>Improve Leadership Capacity at all Levels</td>
<td>Baseline measurement only at this time</td>
<td>46</td>
</tr>
<tr>
<td>B</td>
<td>Strengthen Accountability of Employees and Physicians.</td>
<td>Baseline measurement only at this time</td>
<td>47</td>
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<tr>
<td></td>
<td>Research Funds from Grants &amp; Contracts</td>
<td>For 2012/13, both grants and contracts were down from the previous year.</td>
<td>48</td>
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<tr>
<td>B</td>
<td>Focus on Innovation that has Benefits for Patients &amp; Aligns with Our Mission.</td>
<td>Baseline measurement only at this time</td>
<td>49</td>
</tr>
<tr>
<td>B</td>
<td>Strengthen Partnerships with Learning Institutions</td>
<td>Baseline measurement only at this time</td>
<td>50</td>
</tr>
<tr>
<td>B</td>
<td>Build our Capacity for Interprofessional Research and Interprofessional Education</td>
<td>Baseline measurement only at this time</td>
<td>51</td>
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<tr>
<td>B</td>
<td>Innovate Systems and Processes for Greater Efficiency</td>
<td>Baseline measurement only at this time</td>
<td>52</td>
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<td>B</td>
<td>Develop Funding Models Based on our Priorities.</td>
<td>Baseline measurement only at this time</td>
<td>53</td>
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<td>B</td>
<td>Be Better Environmental Stewards</td>
<td>Baseline measurement only at this time</td>
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Introduction

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

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

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

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

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

Strategic Plan Renewal: Beyond 2013

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

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

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

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

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

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

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

The Patients First icon specifies a patient safety indicator.

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

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

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

Data Quality and Revisions

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

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

Contributors

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

Access Indicators

1.1 Surgery Cancellation Rates

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

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

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

How are we doing?
The graph below shows monthly cancellation rates for the most recent two-year period. The rate of resource-related cancellations has been higher than target since December 2012.

In July, the highest contributing reasons for surgery cancellations for the district were emergency bumps (23) and lack of elective time (16 – 4 HI/7 VG/5 DGH), often related to emergency bumps from earlier in the day and physician not available (9). Emergency bumps were the highest at the HI site (13), as would be predicted due to being the trauma center.

Patient Related reasons continue to decline in positive manner

What are we doing about this?
Contributing to the apparent increase in resource related cancellations is a data integrity issue. A meeting was held & an issue has been identified. Changes to address the issue will be implemented in October 2013.

Plan to remove “lack of elective time code” & ensure other more specific codes available to better develop plan to address

With clinical service planning underway consideration will be given to trauma demand in developing an OR schedule to consider increasing trauma waitlist time at HI/VG

[Text last updated September 2013]
Patient- and Hospital-Related Surgical Cancellation Rates & Total Surgeries for Recent Months

<table>
<thead>
<tr>
<th>Facility</th>
<th>June 2013</th>
<th>July 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Patient-Related Cancellations</td>
<td>Resource-Related Cancellation</td>
</tr>
<tr>
<td>HI</td>
<td>0.6%</td>
<td>3.4%</td>
</tr>
<tr>
<td>VG</td>
<td>1.1%</td>
<td>1.6%</td>
</tr>
<tr>
<td>DGH</td>
<td>3.5%</td>
<td>3.9%</td>
</tr>
<tr>
<td>HCH</td>
<td>0.0%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

Frequency of Data Updates: Monthly  
Data Last Updated: Aug. 2013  
Next Data Update Expected: Oct. 2013
1.2 Wait Times – Elective CT

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

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

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

How are we doing?
The graph below shows the wait times and patient volumes for elective CT at Capital Health. This is the weighted average for the QEII, Dartmouth General, and the Cobequid Community Health Centre combined. The target wait time for CT is 28 days. The July 2013 wait time was 29 days—just one day over the target. There has been a very positive trend over the past year. Even the average monthly wait time for the entire 2012/13 fiscal year was 26 days, which is better than the target of 28 days.

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

What are we doing about this?
Capital Health received funding from the Department of Health and Wellness to replace an end-of-life CT scanner at the Halifax Infirmary site of the QEII. The new scanner has been up and running since March 2011.

[text last updated in 2012]
1.3 Wait Times – Elective MRI

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

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

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

How are we doing?

There is increasing demand as new indications for MRI are validated by evidence. Present demand exceeds capacity so wait times will continue to grow. In July 2013, the average wait time for MRI was 197 days—over seven times longer than the target of 28 days.

As well, effective February 28, 2013, the Nova Scotia Department of Health and Wellness is supporting open, direct access for family physicians and nurse practitioners in the province to order MRI exams for their adult patients. Direct ordering of MRIs will be made available in a phased approach by body region beginning with referrals for central nervous system/head and neck conditions beginning February 28, 2013. Requests will continue to be triaged by radiologists for appropriateness and urgency level as is the current practice for all MRI/CT scan requests.

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

What are we doing about this?
Staffing challenges continue with two technologists retiring at the end of 2012, and an additional technologist resigning June 30, 2013. Currently there is no local training program so we have to recruit nationally. We anticipate that this will change in the near future as Dalhousie University has plans to begin an MRI Specialty Practice program in 2013.

[Last updated in 2012]
1.4 Wait Times - Radiotherapy Treatment

What is being measured?
This indicator measures the wait time, in days, from date 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 mostly hovering around the target of 7 days, but were below the target for June to August 2013. Wait times for intermediate cases have been consistently longer than the target of 14 days, but have been showing some improvement over the last year and a half.

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

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

[Last updated April 2013, except reference to graphs]
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: Sept. 2013                  Next Graph Update Expected: Oct. 2013

Capital Health’s Strategic Indicators Report, October 11, 2013
1.5 Wait Times – Hip Fracture Surgery

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

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

How are we doing?
The target is to have 100% of all cases of hip fracture repair receive their surgery in 48 hours, however, in Q4 of 2012/13 only 75% met the target time. The percentage is essentially the same for Q1 of 2013/14.

What are we doing about this?
Several strategies are being undertaken to increase the number of patients with hip fractures who receive surgery within 48 hours. These strategies include:
- Capital Health is part of Bone & Joint Canada’s steering committee for hip fractures, which provides access to the best practices in the management of hip fractures.
- Clinical pathway was implemented in Q1 2012/13.
- Recommendations for CDHA’s joint plans for 2013/14 have been sent to the Department of Health and Wellness. This request has been put on hold by DHW.
- Increased focus at the HI on OR turnaround time to improve flow.
- Working being done to move the orthopedic trauma waitlist to an electronic platform to better manage & prioritize lists

[text last updated September 2013]
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 the first quarter of 2013/14, only 67% of patients had their surgery within the benchmark of 182 days. For 2013/14 to date, there have been 54 more joints performed than in the same period last year.

What are we doing about this?
Several strategies are being undertaken:
- Recommendations for CDHA’s joint plans for 2013/14 have been sent the Department of Health and Wellness. This request has been put on hold by DHW. While the provincial orthopedic committee reviews the provincial plans
- There is a plan to implement in October a grid for OR to improve planning and the number of joint replacements performed at the HI.
- There is an increased focus at the HI on OR flow with new strategies identified
- A second surgeon at Dartmouth now means three joints can be booked per room instead of just two.

[Text last updated September 2013]
1.7 Wait Times – Knee Replacement

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

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

How are we doing?
The graph below shows the percentage of patients who had their knee replacement surgery within the target wait time of 182 days. The target is to have 100% of all patients' knee replacement surgery performed within 182 days. In the first quarter of 2013/14, 42% of patients had their knee replacement surgery within the target time frame.

What are we doing about this?
Several strategies are being undertaken:
- Recommendations for CDHA’s joint plans for 2013/14 have been sent to the Department of Health and Wellness. This request has been put on hold by DHW.
- While the provincial orthopedics committee review provincial plans
- There is a plan to implement in October a grid for OR to improve planning and the number of joint replacements performed at HI.
- There is an increased focus at the HI on OR flow with new strategies identified.
- A second surgeon at Dartmouth now means three joints can be booked per room instead of just two.
[Text last updated September 2013]
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 2013/14, the rate was 63%; however, the number of overall cases completed in Q1 was up from Q1 of last year.

The waitlist for cataract surgery has grown by 9.7% over the past year. The demand is growing faster than the ability to complete procedures due to resource constraints. There are more than 2,400 patients waiting for cataract surgery at CDHA.

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

What are we doing about this?
OR efficiencies have resulted in the ability of the clinical team to increase the number of cataract surgeries performed per room per day. Effective March 2013, some rooms have increased from 12 cases per day to 14.

A report was sent to the Department of Health and Wellness with recommendations to address the waitlist but the Department has placed this on hold at this time.

[text last updated September 2013]
1.9 Wait Times – Open Heart Surgery

What is being measured?
This indicator is the average wait time for open heart surgery procedures. Coronary artery bypass graft (CABG) and valve replacements are included in the open heart surgery procedure grouping. However, as of April 2013, the wait times are for CABGs only.

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?
Wait Times for open heart surgery are shown in the graph below. For urgent cases, the average wait time has consistently remained under the seven-day target.

The average wait times for scheduled cases have been longer than the target of 42 days for May 2012 to April 2013. They plummeted below target to 12 in May 2013 and to 2 in June 2013. A few patients who no longer needed to be on the list were removed in May. Semi-urgent cases have had wait times that have been longer than the target of 21 days for the months of April 2012 to May 2013, with the exception of December 2012.

What are we doing about this?
All cases sent for cardiac surgery at CH are reviewed weekly by a peer review cardiovascular conference where patients are placed on the list for cardiac surgery and prioritized as to urgency status by consensus decision making. Wait list continue to be monitored and the wait time for patients is adjusted based on acuity.

[Last updated August 2013]
1.10 Wait Times – From Triage to Admission in the Emergency Department

What is being measured?
This indicator is the 90th percentile emergency department wait time from time of triage to time of admission for admitted patients. Clinical Decision Unit patients are not included.

Why is it important?
In 2010, the Institute of Clinical Evaluative Sciences (ICES) identified the emergency department (ED) 90th percentile length of stay for admitted patients as the most important strategic indicator for quality in the ED, and, in fact, as a surrogate marker of overall hospital functioning. The 90th percentile wait time is the time in which 90% of patients end up waiting.

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

How are we doing?
The graph below shows the 90th percentile wait times from triage to admission for the QEII and the Dartmouth General. 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 sites have 90th percentile waits that are well over the target of eight hours.

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

What are we doing about this?
In January 2012, two initiatives started to increase capacity within the Dartmouth ED: 1) expanded hours on the minor side. There was previously only staffing until 7:00 pm. Now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN. This will care for Level 4s and 5s, or stable level 3s. This will be staffed from 11:00 am to 7:00 pm.

[Last updated in 2012]
1.11 Wait Times – From Triage to Physician in the Emergency Department

What is being measured?
This indicator is the average emergency department wait time from the time of triage to the time seen by a physician for CTAS level III cases.

Why is this important?
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 over the last three years. A breakdown by emergency department site is provided. The target time is 30 minutes. All sites have wait times longer than the target of 30 minutes.

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

What are we doing about this?
In January 2012, two initiatives have started that will increase capacity within the Dartmouth ED: 1) expanded hours on the minor side. There was previously only staffing until 7:00 pm. Now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed by an LPN- this will care for Level 4’s & 5’s or stable level 3’s. This will be staffed 11:00 am to 7:00 pm.

Average Emergency Wait Times
Triage to Physician - CTAS Level III

Frequency of Graph Updates: Quarterly
Graph Last Updated: Aug. 2013
Next Graph Update Expected: Oct. 2013
Patient Safety Indicators

1.12 Transmission Rates – MRSA

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

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

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

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

How are we doing?
In 2009, according to the Canadian Nosocomial Infection Surveillance Program (CNISP) the national transmission rate was 0.59 per 1,000 patient days. The rates at Capital Health have been far below the 2009 national rate.

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

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

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

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

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

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

How are we doing?
According to the Canadian Nosocomial Infection Surveillance Program (CNISP), the most recent national rate was 6.4 per 1000 patient days (2009). The rates at Capital Health have been far below the 2009 national rate.

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

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

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

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

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

How are we doing?
The most recent national rate reported in 2011 by the Canadian Nosocomial Infection Surveillance Program (CNISP) was 6.32 per 10,000 patient days. The rate at Capital Health in 2012 was 4.1 per 10,000 patient days.

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

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

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

How are we doing?
In 2010 the overall rate of compliance was 44%. For April to June of 2013, the overall rate was 74%—the highest overall rate yet.

Although, only the “after” rate is above the target of 80%. Greater detail is shown in the graph below.

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

- Launch of new LMS (SHN) training module
- 2012/13 Hand Hygiene campaign (poster, screen saver, etc.)
- Targeted intervention for work groups
- Stop-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 and Family Engagement Pilot Project (implementation late 2013/early 2014)

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

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

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

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

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

How are we doing?
The graph below shows the HSMR for CDHA for fiscal years 2007/08 to 2012/13. 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. In 2012/13 CDHA’s HSMR score returned to a level that was statistically significantly higher/worse than the 2009/10 national average.

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

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

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

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

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

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

[Last Updated September 2013]
1.18 Patient Safety Culture

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

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

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

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

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

[Last updated August 2013]

Overall Grade on Patient Safety from Recent Capital Health Patient Safety Culture Surveys

<table>
<thead>
<tr>
<th>Year</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Acceptable</th>
<th>Poor</th>
<th>Failing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>4%</td>
<td>7%</td>
<td>8%</td>
<td>7%</td>
<td>2%</td>
</tr>
<tr>
<td>2010</td>
<td>29%</td>
<td>43%</td>
<td>44%</td>
<td>8%</td>
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<tr>
<td>2012</td>
<td>50%</td>
<td>41%</td>
<td>14%</td>
<td>7%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Frequency Tracked: Every two years  
Last Updated: October 2012  
Next Update Expected: 2014
1.19 Completion of Patient Safety Training

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

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

**How are we doing?**
The graph below shows the percentage of CDHA employees, medical staff, learners, and volunteers who completed at least one patient safety course. The annual target is to reach 100%. For April to July of 2013, 19% have completed a patient safety training course.

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

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

1.20 Length of Stay – Number of Conservable Days

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

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

Using data from the first several months of 2013/14 to estimate conservable days for the full fiscal year makes it look as if the target will not be met.

It should be noted that variation from year to year can occur not only as a result of changes in the average lengths of stay but also as a result of year-to-year adjustments in expected lengths of stay, as determined by the Canadian Institute for Health Information. And as such, if the expected length of stay decreases for a given case mix group, the conservable days for a given facility can increase despite the average length of stay remaining unchanged.

Conservable Days for Typical Cases at CDHA

### 1.21 Occupancy Rates

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

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

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

The graphs below show the yearly occupancy rates for services at the QEII and the Dartmouth General. In 2012/13, the following services were below the target of 90% (favorable): QEII Surgical, QEII ICU, and DGH ICU/CCU. All other services were above the target (unfavorable). Many services showed an improvement over the previous year. This trend of improvement extends to the hospital totals as well, but they were still above the target of 90% for 2012/13 (unfavorable).

For the first five months of 2013/14, the most notable change was the overall rate for the QEII dropped to below the target (favorable). The occupancy rate at the Dartmouth General remained above target for this period.

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

Occupancy Rate

<table>
<thead>
<tr>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14 Apr-Aug</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 West - Surg/FM</td>
<td>90%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
</tr>
<tr>
<td>3 East - FM/Pall Care</td>
<td>90%</td>
<td>93%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>ICU/CCU</td>
<td>85%</td>
<td>88%</td>
<td>87%</td>
<td>88%</td>
</tr>
<tr>
<td>FM/Int Med</td>
<td>80%</td>
<td>85%</td>
<td>82%</td>
<td>83%</td>
</tr>
<tr>
<td>Total (Excluding Transitional Care)</td>
<td>90%</td>
<td>93%</td>
<td>91%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Target: 90% or less

Frequency Tracked: Monthly
Graphs Last Updated: Sept. 2013
Next Graph Update Expected: Oct. 2013
1.22 Emergency Department – Left Without Being Seen

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

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

**How are we doing?**
The graph below shows the percentage of patients who left the emergency department without being seen (all triage acuity levels combined). A breakdown by emergency department site is shown. The target is to keep walkouts below 2% all across Capital Health, but all sites are currently over the target of 2%. The exception is Hants where only 0.9% left without being seen in August 2013.

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

**What are we doing about this?**
A failure modes and effects analysis process is being applied to the issue of patients leaving without being seen to see if there are root causes, and to determine the factors that influence patients’ decisions to leave which will help focus on the development of solutions.

In January, two initiatives have started that will increase capacity within the Dartmouth General ED: 1) expanded hours on the minor side. This was previously only staffed until 7:00 pm and now it is staffed until 11:00 pm; and 2) trial period of a chair zone which will be staffed from 11 am to 7 pm.
1.23 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 Capital Health sites. These graphs represent LTC patients from all Capital Health facilities. Both acute care and mental health LTC patients are included.

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

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

How are we doing?
The graphs below show the number of Capital Health patients placed and waiting to be placed into LTC facilities. In August 2013, the total number of patients at all Capital Health facilities who were waiting to be placed in LTC facilities was 175. This is above the target of 75. Lengths of stay are only a snapshot of what is documented in the LTC/ALC database at the time of publication of this report. August 2013 data were extracted on September 10th, 2013.

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

In Capital Health, as of September 18th, 2013, there were 774 people in the community waiting to be placed in LTC facilities. The number of people waiting in the community during the same time last year (September 19th, 2012) was 752 (source: Department of Health and Wellness SEAscape database).

[Last updated September 2013]
Capital Health Patients *Waiting to be Placed* in LTC
August 2011 to August 2013

Capital Health Patients *Placed* in LTC
August 2011 to August 2013

Graph Update Frequency: Monthly      Graphs Last Updated: Sept. 2013      Next Graph Update Expected: Oct. 2013
1.24 Strengthen Community-Based Care for Chronic Disease

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

**Goal:** Significant increase over baseline of chronic disease management occurring 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.

We will focus on the most common chronic diseases – hypertension, heart disease, COPD, and diabetes.

Our target is a 5 per cent reduction, or 425 fewer return visits. This will show that we have been successful in diverting patients from the hospital into a community setting. We are looking to avoid bringing stable patients to the hospital setting when they can be better supported in the community.

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

**Why is it important?**
Our aging population and growth in chronic disease means that community-based models are crucial.

We have 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?**
Current baseline results: Total cut codes for annual return visits to the clinics directly related to hypertension, heart disease, COPD, and diabetes in 2011/12 was 8,500.

**What are we doing about this?**
Barbara Hall, VP Person-Centred Health and David Anderson, chief and head of the Department of Medicine, have convened an action team to tackle this challenging measure. The team will develop an action plan and timeline by June 30, 2013. Three major actions for achievement of this 2016 goal are:

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

[Last updated: August 2013]
1.25 Improve Quality of Care in Transitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**What is being measured?**

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

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

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

**Why is it important?**

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

**How are we doing?**

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

**What are we doing about this?**

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

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

[last updated: August 2013]
2 Citizen and Stakeholder Engagement and Accountability

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

**Strategy:** Citizen and Stakeholder Engagement and Accountability  
**Goal:** Significant increase in number of individuals reporting that Capital Health has supported them in playing a key role in managing their own health.  
**Measure:** 10 point increase in percentage of residents who say they have received support in managing their own health.

**What is being measured?**

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

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

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

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

**Why is it important?**

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

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

**How are we doing?**

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

**What are we doing about this?**

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

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

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

**Strategy:** Citizen and Stakeholder Engagement and Accountability  
**Goal:** Patients or their surrogates report that their involvement in decision-making related to their care met or exceeded their expectations.  
**Measure:** 10 point increase in the percentage of patients responding positively to a survey question about being consulted in decision-making about their care.

**What is being measured?**

We currently collect data on patients’ assessment of their involvement in decision-making through our patient experience survey.

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

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

**Why is it important?**

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

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

**How are we doing?**

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

**What are we doing about this?**

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

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

[Last updated: August 2013]
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 point increase in the percentage of Capital District residents surveyed who report a high degree of familiarity with the concept of appropriateness of care.

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**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 care, anticipating that this will pull the whole curve of respondents upward.

**Why is it important?**

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

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

**How are we doing?**

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

**What are we doing about this?**

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

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

[last updated: August 2013]
3  Transformational Leadership

3.1 Absenteeism

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

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

How are we doing?
A graph of the average sick hours per eligible employee per month at CDHA is shown below. The target is to be at or below 6.15 hours per month. So far in 2013/14, the average monthly sick hours is above target at 6.77.
The organization is currently experiencing a high rate of absenteeism. This is during a time in which there are hiring challenges for nursing positions throughout the organization. These challenges result in more staff having to work even more overtime.

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

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

People Services has also teamed up with Wellness and Safety to help deliver education opportunities to assist managers with the utilization of employment contracts around culpable sick time, improving accessibility by means of identification/promotion of services. Relevant quality operational indicators are being identified and will be used to determine the best services available to meet these goals. Measures have been put in place to make pre-hire OH screening mandatory prior to hiring to ensure the new hire is a fit for the position. [Last updated July 2013].
### 3.2 Overtime

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

According to the Our Promise: 2013 Milestones, the goal was to reduce overtime by 10% by 2012/2013. The baseline year is 2009/10, in which 2.1% of worked hours were overtime hours.

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

**How are we doing?**
The graph below shows the percentage of overtime worked at CDHA. For the 2012/13 fiscal year, the percentage of overtime hours worked was 1.5%—well below the target of 1.89%.

So far in 2013/14 (April to August), the percentage of overtime hours worked is up from 2012/13 and 2011/12 but is still better than target. There was an increase challenge in hiring staff over this fiscal year leaving many positions vacant for longer periods and higher frequencies.

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

[Last updated June 2013]
3.3 Employee Survey

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

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

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

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

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

Selected Results From the 2009 & 2011 Employee Surveys

Frequency Tracked: Every two years
Last Updated: June 2011
Next Update Expected: 2013
3.4 Employee Survey – Accreditation Canada Worklife Pulse

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

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

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

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

Results of analysis also showed that engagement of employees for sustainable change required action at the interdisciplinary team level. In order to support improved employee satisfaction at the “front-line” of care and service provision, a toolkit with individualized data was created, and facilitation was provided to teams for action planning based on these more specific results. As of June 1, all Quality and Patient Safety Teams had identified two- to three-item key areas for improvement based on their individual Worklife Pulse results.

[Last updated September 2013]
3.5 Physician Survey

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

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

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

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

Selected Results from the 2011 Capital Health Physician Survey

<table>
<thead>
<tr>
<th>Survey Category</th>
<th>Unfavorable</th>
<th>Neutral</th>
<th>Favorable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Colleagues</td>
<td>4%</td>
<td>11%</td>
<td>87%</td>
</tr>
<tr>
<td>Respect</td>
<td>9%</td>
<td>20%</td>
<td>69%</td>
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<tr>
<td>Evidence of Transformational Leadership</td>
<td>24%</td>
<td>59%</td>
<td>17%</td>
</tr>
<tr>
<td>Co-Leadership</td>
<td>26%</td>
<td>34%</td>
<td>37%</td>
</tr>
<tr>
<td>Trust Capital Health Management</td>
<td>23%</td>
<td>37%</td>
<td>29%</td>
</tr>
<tr>
<td>Engagement with Capital Health</td>
<td>28%</td>
<td>35%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Frequency Tracked: Every two years  
Last Updated: June 2011  
Next Update Expected: 2013
What is being measured?
In 2012, we conducted a survey of employees and physicians on three dimensions of leadership:

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

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

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

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

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

There were no statistically significant differences between physicians and employees.

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

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

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

**Strategy:** Transformational Leadership

**Goal:** Staff, management and physicians at all levels report being held accountable for their performance.

**Measure:** 20 point increase in the percentage of staff, management and physicians responding most positively on survey items measuring self reported accountability.

**What is being measured?**

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

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

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

**Why is it important?**

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

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

**How are we doing?**

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

**What are we doing about this?**

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

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

[Last updated: August 2013]
4 Innovating Health and Learning

4.1 Research Funds from Grants & Contracts

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

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

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Grants</th>
<th>Contracts</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/05</td>
<td>$6,450,879</td>
<td>$5,308,993</td>
<td>$11,759,872</td>
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<td>$7,139,344</td>
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<td>2008/09</td>
<td>$9,993,550</td>
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<tr>
<td>2010/11</td>
<td>$9,485,073</td>
<td>$4,739,574</td>
<td>$14,224,647</td>
</tr>
<tr>
<td>2011/12</td>
<td>$10,369,811</td>
<td>$6,891,709</td>
<td>$17,261,520</td>
</tr>
<tr>
<td>2012/13</td>
<td>$9,354,823</td>
<td>$6,349,929</td>
<td>$15,704,752</td>
</tr>
</tbody>
</table>

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

**Strategy:** Innovating Health and Learning  
**Goal:** New innovations are demonstrably aligned with organizational goals, have clear benefits for patients, and contribute to sustainability.  
**Measure:** Implementation of a health technology assessment process for all new major capital equipment expenditures over $500,000, and all new externally provided diagnostic testing which costs more than $10,000 annually per type of test.

---

**What is being measured?**

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

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

**Why is it important?**

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

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

**How are we doing?**

Current baseline results are not yet available.

**What are we doing about this?**

Catherine Gaulton, Vice-President, Performance Excellence & General Counsel, and Pat McGrath, Integrated Vice-President, Research and Innovation, have convened an action team to develop an action plan to fulfill this goal.

Two major actions for achievement of this 2016 goal are:

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

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

**Strategy:** Innovating Health and Learning

**Goal:** Partners in the academic health learning network report a high degree of quality in their relationship.

**Measure:** 85% positive response by academic partners on survey items related to the quality of the partnership.

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

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

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

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

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

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

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

**Strategy:** Innovating Health and Learning  
**Goal:** Increase opportunities for interprofessional research and interprofessional education  
**Measure:** 50% increase in the percentage of new, Research Ethics Board approved research initiatives that are interprofessional, and in the number of hours of interprofessional education offered annually

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

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

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

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

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

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

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

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

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

[last updated: August 2013]
5 Sustainability

5.1 Innovate Systems and Processes for Greater Efficiency

**Strategy:** Sustainability

**Goal:** Optimize resources to improve organizational (system) performance, quality and efficiency.

**Measure:** 60% of typical cases for identified Case Mix Groups have an Average Length of Stay (ALOS) equal to or less than the Expected Length of Stay (ELOS).

---

**What is being measured?**

We looked at this goal from the perspective of optimizing the use of clinical resources. As a result, our measure relates to ALOS and ELOS. ALOS is the actual – the Average Length of Stay for patients with a particular diagnosis. ELOS or Expected Length of Stay is the objective – how long, based on national data, we would expect patients with that diagnosis to be in hospital. It’s important to note that here we are referring to typical cases.

We will be focusing on three case mix groups – Heart failure without Coronary Angiogram; Chronic Obstructive Pulmonary Disease; and Ischemic Event of Central Nervous System – but not to the exclusion of others.

**Why is it important?**

We are focused on these three groups because our results need improvement in these areas, and if we address them we will see our overall results improve. These three areas are in the top 10 case mix groups by volume. Results in these areas connect well with other key indicators we are tracking.

And finally – importantly – we know that there is a strong correlation of these areas with Emergency department flow. Delays in discharging patients in these case mix groups affect the whole system – right back to the patient in Emerg waiting for a bed.

**How are we doing?**

Current baseline results: In 2009-10, the percentages of typical cases for identified Case Mix Groups with an ALOS equal to or less than the ELOS are as follows:

- Heart failure without Coronary Angiogram: 48%
- Chronic Obstructive Pulmonary Disease: 56%
- Ischemic Event of Central Nervous System: 50%

**What are we doing about this?**

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

- For the CMGs identified pursue targeted strategies to reduce differential between ELOS & ALOS for typical cases
- Design, develop, and implement a District Clinical Services Plan
- Develop a district wide facilities plan to optimize efficiencies and effective management related to utilization of space and resources

[last updated: August 2013]
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?**
Current baseline results: N/A

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

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

[last updated: August 2013]
5.3 Be Better Environmental Stewards

**Strategy:** Sustainability

**Goal:** Capital Health is independently recognized as a leader in adopting practices and processes that minimize the impact on the environment.

**Measure:** 15% reduction in total annual electrical power consumption.

---

**What is being measured?**

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

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

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

**Why is it important?**

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

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

**How are we doing?**

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

**What are we doing about this?**

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

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

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

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>Q1 10/11</th>
<th>Q2 10/11</th>
<th>Q3 10/11</th>
<th>Q4 10/11</th>
<th>Q1 11/12</th>
<th>Q2 11/12</th>
<th>Q3 11/12</th>
<th>Q4 11/12</th>
<th>Q1 12/13</th>
<th>Q2 12/13</th>
<th>Q3 12/13</th>
<th>Q4 12/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Acquired Infections</strong></td>
<td>MRSA Transmission (per 1000 patient days)</td>
<td>&lt; 0.59</td>
<td>0.6</td>
<td>0.5</td>
<td>0.4</td>
<td>0.37</td>
<td>0.29</td>
<td>0.46</td>
<td>0.32</td>
<td>0.53</td>
<td>0.38</td>
<td>0.67</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. difficile Incidence (per 1000 patient days)</td>
<td>&lt; 0.63</td>
<td>0.30</td>
<td>0.25</td>
<td>0.22</td>
<td>0.27</td>
<td>0.29</td>
<td>0.33</td>
<td>0.14</td>
<td>0.21</td>
<td>0.20</td>
<td>0.31</td>
<td>0.30</td>
<td>0.30</td>
</tr>
<tr>
<td></td>
<td>VRE Incidence (per 10,000 patient days)</td>
<td>&lt; 11.3</td>
<td>0.25</td>
<td>0.00</td>
<td>0.00</td>
<td>0.13</td>
<td>0.00</td>
<td>0.00</td>
<td>0.79</td>
<td>0.66</td>
<td>0.30</td>
<td>0.07</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td><strong>DGH Quick Response Team</strong></td>
<td>DGH Code Blue Count (Average codes per month)</td>
<td>&lt; 3</td>
<td>2.3</td>
<td>1.3</td>
<td>0.7</td>
<td>1.6</td>
<td>1.3</td>
<td>2.3</td>
<td>1.7</td>
<td>3.3</td>
<td>2.3</td>
<td>0.7</td>
<td>0.67</td>
<td>2.67</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>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013 (Apr-Jun)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hand Hygiene</strong></td>
<td>Compliance Before Patient Contact</td>
<td>80%</td>
<td>29%</td>
<td>54%</td>
<td>46%</td>
<td>62%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Compliance After Patient Contact</td>
<td>80%</td>
<td>55%</td>
<td>75%</td>
<td>74%</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overall Compliance</td>
<td>80%</td>
<td>44%</td>
<td>66%</td>
<td>61%</td>
<td>74%</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Indicator</th>
<th>Target</th>
<th>2008/09</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mortality</strong></td>
<td>Hospital Standardized Mortality Ratio (HSMR)</td>
<td>≤ 100</td>
<td>109 *</td>
<td>113 *</td>
<td>105</td>
<td>99</td>
<td>107</td>
</tr>
<tr>
<td><strong>Patient Safety Culture Survey</strong></td>
<td>“Excellent” &amp; “Very Good” Responses</td>
<td>47%</td>
<td></td>
<td></td>
<td>51%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Acceptable” Responses</td>
<td>44%</td>
<td></td>
<td></td>
<td>41%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Poor” and “Failing” Responses</td>
<td>10%</td>
<td></td>
<td></td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total of “Excellent”, “Very Good”, and “Acceptable” Responses Combined</td>
<td>90%</td>
<td></td>
<td></td>
<td>91%</td>
<td></td>
<td>92%</td>
</tr>
<tr>
<td><strong>Annual Patient Safety Training</strong></td>
<td>Percentage Completion</td>
<td>100%</td>
<td>30%</td>
<td>31%</td>
<td>25%</td>
<td>39%</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix B: Access (Wait Times) Scorecard

<table>
<thead>
<tr>
<th>Treatment / Procedure</th>
<th>Target Wait Time</th>
<th>Location</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Computed Tomography (CT)</td>
<td>28 days</td>
<td>Capital Health</td>
<td>29 days</td>
</tr>
<tr>
<td>Magnetic Resonance Imaging (MRI)</td>
<td>28 days</td>
<td>QEII</td>
<td>197 days</td>
</tr>
<tr>
<td>Radiotherapy – Intermediate Cases</td>
<td>14 days</td>
<td>QEII</td>
<td>19 days</td>
</tr>
<tr>
<td>Radiotherapy – Urgent Cases</td>
<td>7 days</td>
<td>QEII</td>
<td>5 days</td>
</tr>
<tr>
<td>Hip Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Capital Health</td>
<td>67% of cases completed within target (Q1 2013/14)</td>
</tr>
<tr>
<td>Knee Replacement</td>
<td>100% of cases completed within 26 weeks</td>
<td>Capital Health</td>
<td>42% of cases completed within target (Q1 2013/14)</td>
</tr>
<tr>
<td>Hip Fracture Repair</td>
<td>100% of cases completed within 48 hours</td>
<td>Capital Health</td>
<td>76% of cases completed within target (Q1 2013/14)</td>
</tr>
<tr>
<td>Cataract Surgery</td>
<td>100% of cases completed within 16 weeks</td>
<td>Capital Health</td>
<td>63% of cases completed within target (Q1 2013/14)</td>
</tr>
<tr>
<td>CABG – Urgent Cases</td>
<td>7 days</td>
<td>QEII</td>
<td>1 day (August 2013)</td>
</tr>
<tr>
<td>CABG – Semi-Urgent Cases</td>
<td>21 days</td>
<td>QEII</td>
<td>2 days (August 2013)</td>
</tr>
<tr>
<td>CABG – Scheduled Cases</td>
<td>42 days</td>
<td>QEII</td>
<td>36 days (August 2013)</td>
</tr>
<tr>
<td>ED – 90th Percentile Wait Time from Triage to Admission</td>
<td>8 hours</td>
<td>QEII</td>
<td>22 hours (August 2013)</td>
</tr>
<tr>
<td>ED – Average Wait Time from Triage to Physician: CTAS Level 3 (Urgent)</td>
<td>30 minutes</td>
<td>DGH</td>
<td>148 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>QEII</td>
<td>165 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCHC</td>
<td>73 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HCH</td>
<td>61 minutes</td>
</tr>
</tbody>
</table>
Appendix C: Strategic Streams

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

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

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

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

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

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

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

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

Qmentum Quality Dimensions:

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

**Accessibility** - providing timely and equitable services

**Safety** - keeping people safe

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

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

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

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

**Efficiency** - making the best use of resources
Appendix E: Our Promise in Action Poster
Appendix F: Summary of the 14 Areas of Focus with Respect to the 2013/14 Targets

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

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

- Reece Bearnes, Performance Excellence Program
- Gail Blackmore, Performance Excellence Program
- Mary Bourque, Occupational Health
- Sara Brown, People Services
- Pam Currie, Occupational Health
- Susan Delaney, Diagnostic Imaging
- Lisa Dillman, Finance and Decision Support
- Denise Hatchette, Finance and Decision Support
- Margaret Ivey, Heart Health & Critical Health
- Amanda Murphy, Finance and Decision Support
- Marsha Greenan, Finance and Decision Support
- Nancy MacDonald, Finance and Decision Support
- Tammy MacDonald, Infection Control
- Joel Maxwell, Performance Excellence Program
- Lynn Molloy, Department of Surgery
- Kim Ryan, Performance Excellence Program
- Stacey Squires, Perioperative Nursing
- Sarah Teal, People Services
- Jodie Trembley, Cancer Care Program
- David Urquhart, Department of Emergency Medicine

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