Balanced Scorecard Q3 2017-18

RUNNYMEDE HEALTHCARE CENTRE

Priority	Indicator	Target	Q1	Q2	Q3	Q4	YTD	Page
Strategic Direction 1: YOU FIRST								
Patient Experience	**Overall patient satisfaction score - Medically Complex (MC) - Annual**	83.1%	Annual				**82.4%**	1
	Patient satisfaction score - Low Tolerance Long Duration (LTLD) program*	70%	**65.2%**	**74.1%**	N/A		**69.7%**	2
Customer Service Excellence	Percentage of complaints acknowledged within 5 days	100%	**100%**	**100%**	**100%**		**100%**	3
	Overall patient experience score	90%	**100%**	**100%**	**94%**		**98%**	4
Staff Experience	Staff engagement score - Biannual	70%	Biannual					5
	Turnover rate	5.0%	**4.6%**	**4.9%**	**4.4%**		**4.6%**	6
	Sick time days	2.00	**1.95**	**2.27**	**3.07**		**2.43**	7
	Education as a percent of total expenses	0.25%	**0.31%**	N/A	N/A		N/A	8
Strategic Direction 2: LEAD INNOVATION								
Innovative Care Delivery	Number of improvement/process redesign projects initiated to support innovation	2/year	**2**	**0**	**0**		**2**	9
Extending Our Reach	Number of initiatives implemented leveraging technology to meet patient needs	4	**0**	**1**	**2**		**3**	10
Establish Partnerships	Number of new strategic partnerships	1/year	**1**	**0**	**0**		**1**	11
Strategic Direction 3: ACCESS & SUPPORT								
Information Access & Security	Percentage of electronic Patient Record (ePR) strategy implemented	TBD						12
Service Delivery	**Alternate Level of Care (ALC) Rate**	7.0	**5.5**	**4.7**	N/A		**5.0**	13
	New Pressure Ulcers (Stage 2 - 4)	2.5%	**3.5%**	**3.1%**	N/A		**3.1%**	14
	Falls with harm - Medically Complex	0.65	**0.10**	**0.99**	**0.20**		**0.43**	15
	Falls with harm - LTLD	1.57	**1.46**	**2.42**	**1.78**		**1.89**	16
	Emergency Department (ED) Transfer rate	14.0	**8.3**	**11.2**	**9.7**		**9.7**	17
Community Partnerships	Number of new community partnerships	1/year	**1**	**1**	**3**		**5**	18
Strategic Direction 4: SUPPORTING TRANSFORMATION								
Environmental Sustainability	Total waste generation reduction	18.0%	**18.7%**	**28.5%**	**19.5%**		**20.6%**	19
	Waste diversion rate to recycling	15.0%	**15.6%**	**22.5%**	**18.9%**		**18.9%**	20
Financial Position	Total margin	0%	**1.36%**	**1.46%**	**10.78%**		**10.78%**	21
	Current ratio	2.50	**7.30**	**4.70**	**7.70**		**7.70**	22
	Percentage of non-Ministry of Health and Long-Term Care revenue	13.3%	**14.5%**	**14.4%**	**13.5%**		**13.5%**	23
Accountability and Support	Employee Performance Evaluation completion rate	100%	**90%**	**89%**	N/A		**89%**	24
	Percentage of Individual Accountablity Plans completed for leadership team	100%						25

Last Revised: March 1, 2018

Legend

Quality Improvement Plan indicator

* 'Would you recommend this hospital to your friends and family?' Definitely yes response is positive.

Results	
G	Equal to or outperforming target
Y	Within 10% of target
R	Underperforming target by greater than 10%

Overall Patient Satisfaction Score - Medically Complex (MC)

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Annual	Internal, Health Quality Ontario	NRC Health

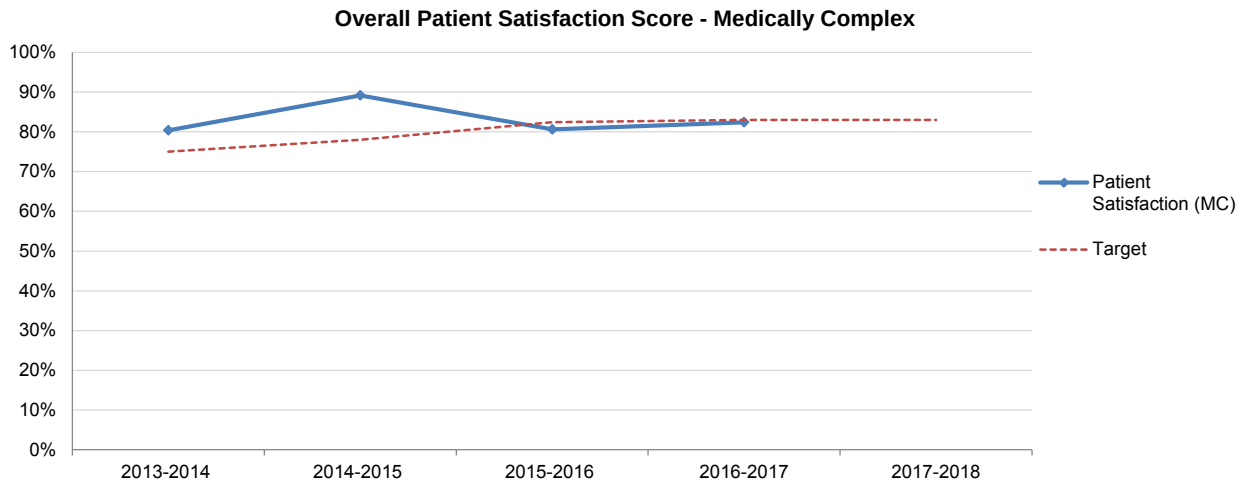
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
					83.0%	Opportunities for Improvement

Definition

NRC Health: Patient Satisfaction - "Overall quality of care/services rating"

Significance

Design and implement a patient experience strategy customized to Runnymede's population and supporting ongoing safe, high-quality patient care.



Analysis

Although Runnymede has not achieved its target of 83%, the overall patient satisfaction score has increased from 80.6% to 82.4%.

Action Plan	Lead	Due Date	Current Status
Revise Patient Family Advisory Committee structure and mandate adopting patient and family centred approach including input into quality initiatives	Director, Quality and Risk Management	31-Mar-18	In progress
Implement Floor based Patient/Family meetings	Director, Patient Care	31-Mar-18	Completed
Implement nursing service expectation standards	Director, Patient Care	31-Mar-18	Completed
Implementation of online patient feedback and safety and risk learning system including accessibility to patients/families	Director, Quality and Risk Management	31-Mar-18	In progress
Clinical operation audits to address experience and safety related concerns e.g. medication safety, environmental clutter/cleanliness, customer excellence tenets	Director, Patient Care	31-Mar-18	In progress
Video story-telling	Director, Communications	31-Mar-18	In progress
Develop a Patient Experience Framework	Director, Quality and Risk Management	31-Mar-18	In progress
Introduce other ways of collecting patient experience feedback.	VP, Strategy, Quality & Clinical Programs	31-Mar-18	In progress

Name	Signature	Date

Patient Satisfaction Score - Low Tolerance Long Duration (LTLD)

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal, Ontario Hospital Association	NRC Health

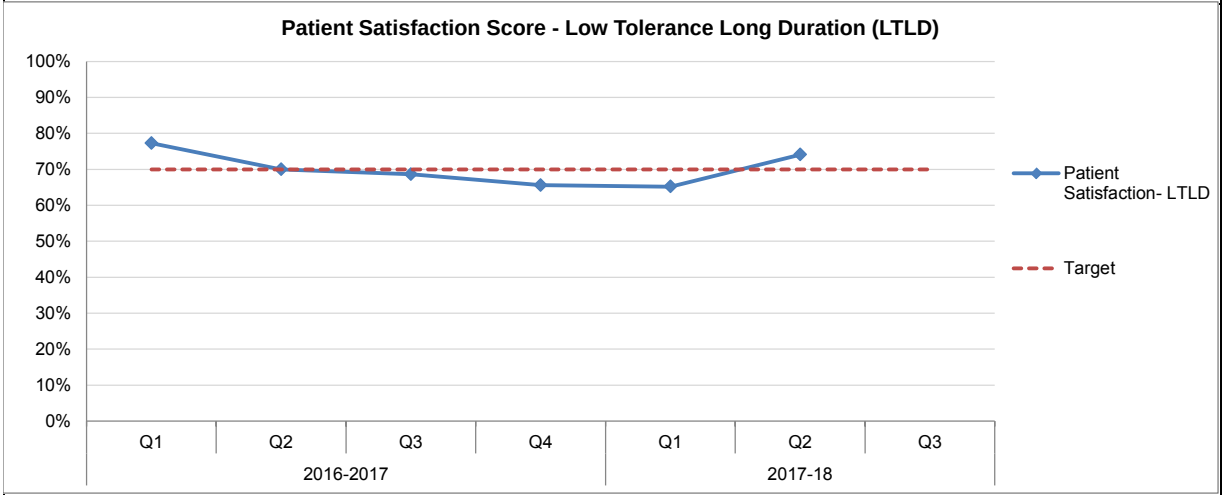
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
65.2%	74.1%	N/A		69.7%	70.0%	Opportunities for Improvement

Definition

NRC Health: Percentage of respondents who responded positively to the question, "Would you recommend this hospital to your friends and family?" A positive response is "definitely yes".

Significance

Design and implement a patient experience strategy customized to Runnymede's population and supporting ongoing safe, high-quality patient care.



Analysis

Runnymede is trending slightly downwards in this indicator. The calculations for this indicator have recently changed whereby a positive answer is "definitely yes".

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Video story-telling	Director, Communications	31-Mar-18	In progress
Develop a Patient Experience Framework	Director, Quality and Risk Management	31-Mar-18	In progress
Continue to receive feedback using the Quality Counts survey on patient/family experience during the first few weeks after admission.	VP, Strategy, Quality and Clinical Programs	31-Mar-18	In progress
Implement a corporate wide customer service strategy.	Director, Communications	30-Nov-17	In progress

Name	Signature	Date

Percentage of complaints acknowledged within 5 days

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal	Patient Relations Data

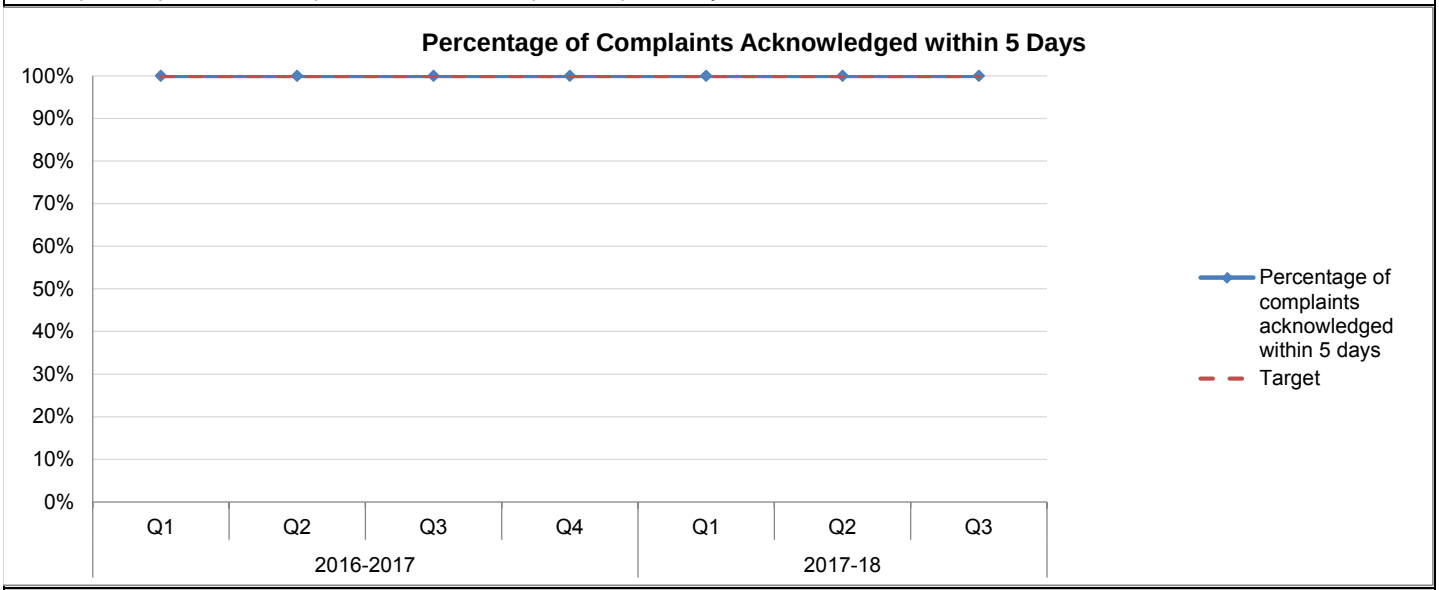
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
100%	100%	100%		100%	100%	Indicator Meets or Exceeds Performance Target

Definition

Percentage of complaints where the complainant has been informed of the status of the review of the complaint within five days from receipt.

Significance

Our goal is for every patient at Runnymede to experience courteous, compassionate care and service provided by our friendly and knowledgeable staff, physicians and volunteers. As part of the patient experience strategy as well as in alignment with the *Excellent Care For All* Act, 2010, having a formal and responsive patient relations process to resolve complaints expeditiously is essential.



Analysis

We continue to meet our target of acknowledging compliaints and concerns within 5 days 100% of the time.

Action Plan	Lead	Due Date	Current Status
Maintain current performance.	VP, Strategy, Quality and Clinical Programs	31-Mar-18	In progress

Name	Signature	Date

Overall Patient Experience Score

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal	Patient Relations

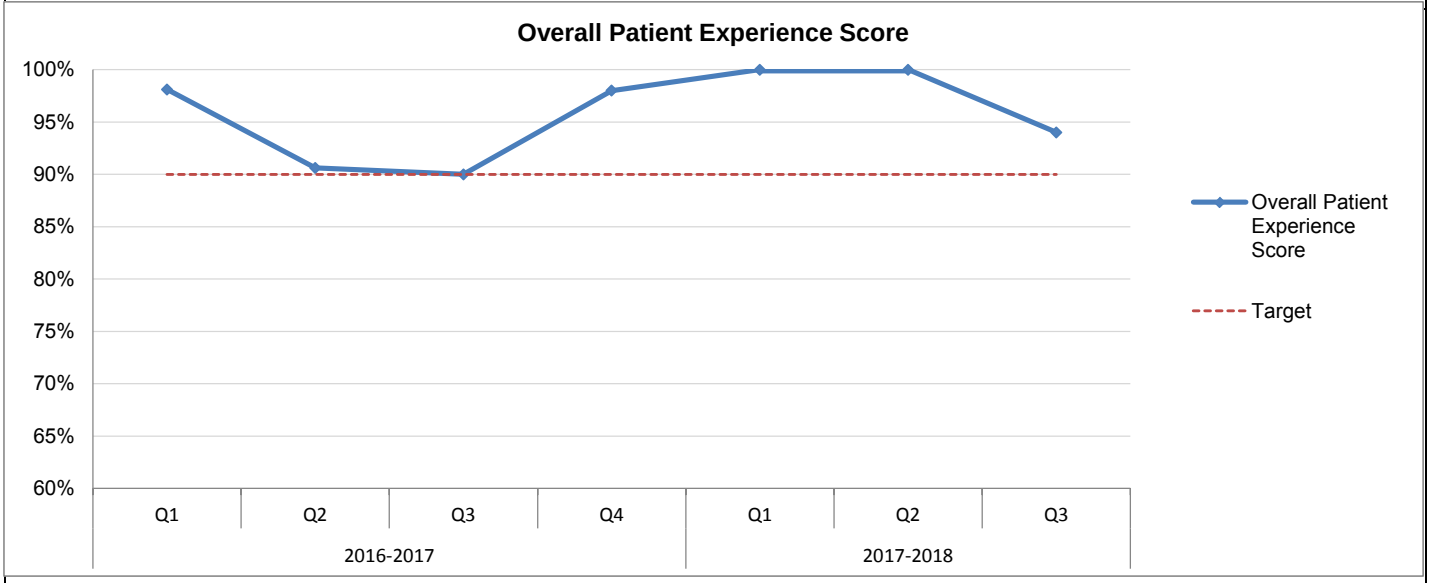
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
100%	100%	94%		98%	90%	Indicator Meets or Exceeds Performance Target

Definition

This indicator uses the internal Quality Counts survey with performance measured by responses of meet or exceeds expectations divided by total number of responses.

Significance

Eliciting feedback from patients and engaging them in their care and health care delivery affords an opportunity to highlight and address aspects of the care experience that need improvement and to monitor performance with regard to meeting patient experience goals in the delivery of care.



Analysis

Q3 performance exceeds the target of 90%. Runnymede will continue to encourage patients and families to complete these surveys with the Activationists.

Action Plan	Lead	Due Date	Current Status
Maintain current performance.	Vice President, Strategy, Quality & Clinical Programs	30-Sep-17	Completed

Name	Signature	Date

Staff Engagement Score

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Bi-annual	Internal	Metrics@Work

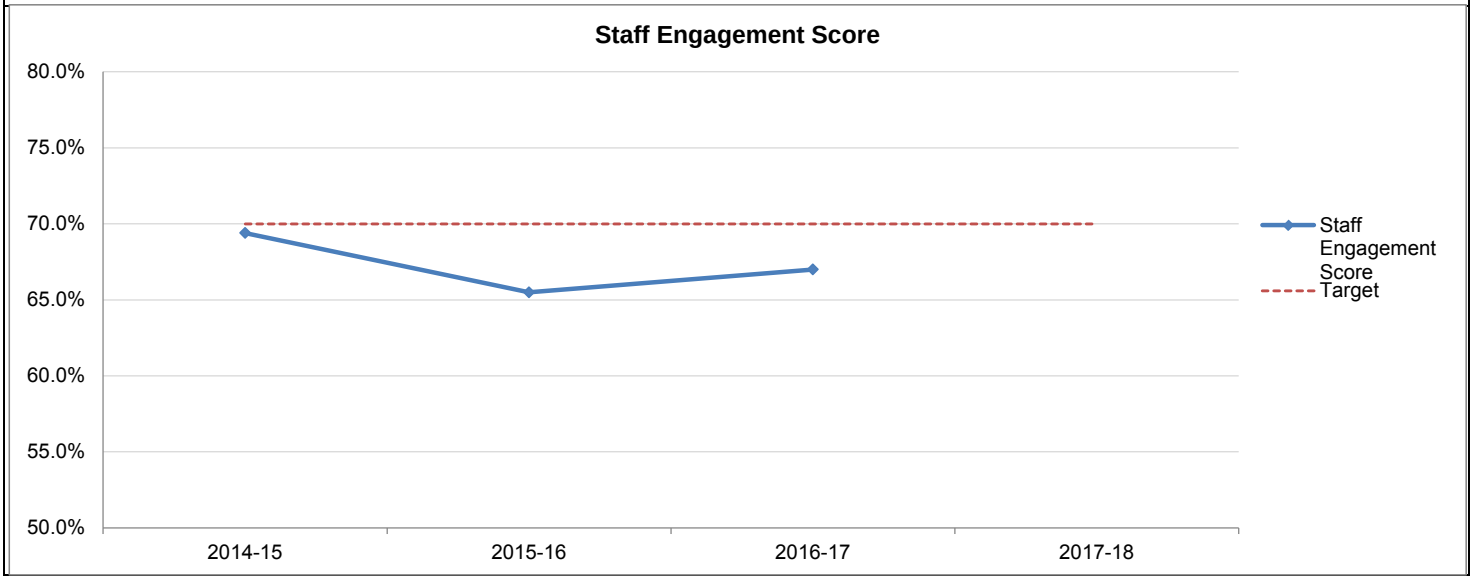
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
Bi-annual					70.0%	Opportunities for Improvement

Definition

Organizational engagement represents employees' perceived relationships with their organization, primarily reflected in the form of emotional commitment to the organization, a willingness to remain (or lack of interest in leaving) and a sense of belonging to the organization. Survey is conducted by Metrics@Work.

Significance

Organizational engagement is often predicted by factors such as leadership, integrity and respect perceived alignment between senior leadership decision-making and positive impacts on one's day-to-day work, trust in one's supervisor, being appropriately compensated (both in terms of pay and benefits), and being part of an organization that supports quality service and ongoing improvement.



Analysis

A full Engagement survey is not scheduled to until 2019, with a shorter pulse survey scheduled for 2018. It is important to continue organizational efforts to identify areas for opportunity and develop actions and implement between now and the next set of surveys. Areas of opportunity have been identified and actions plans developed and are in the process of implementation. Regular contact with Managers has been built into the plan to ensure the plans are

Action Plan	Lead	Due Date	Current Status
Results shared with Operations Committee to develop action plans.	VP, HR & OD	25-Apr-17	Completed
Leaders are meeting with their departments to develop action plans for the three areas for opportunities	VP, HR & OD	30-Jun-17	Completed
Corporate action plan developed and being implemented with a completion dated of Feb 2018	VP, HR & OD	31-May-17	Completed
Departments to work on action plans and complete by December 31, 2017	VP, HR & OD	31-Dec-17	In progress

Name	Signature	Date
Richard Mendonca		03/05/2017

Turnover Rate

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Quarterly	Ontario Hospital Association, Price Waterhouse Coopers	Human Resources

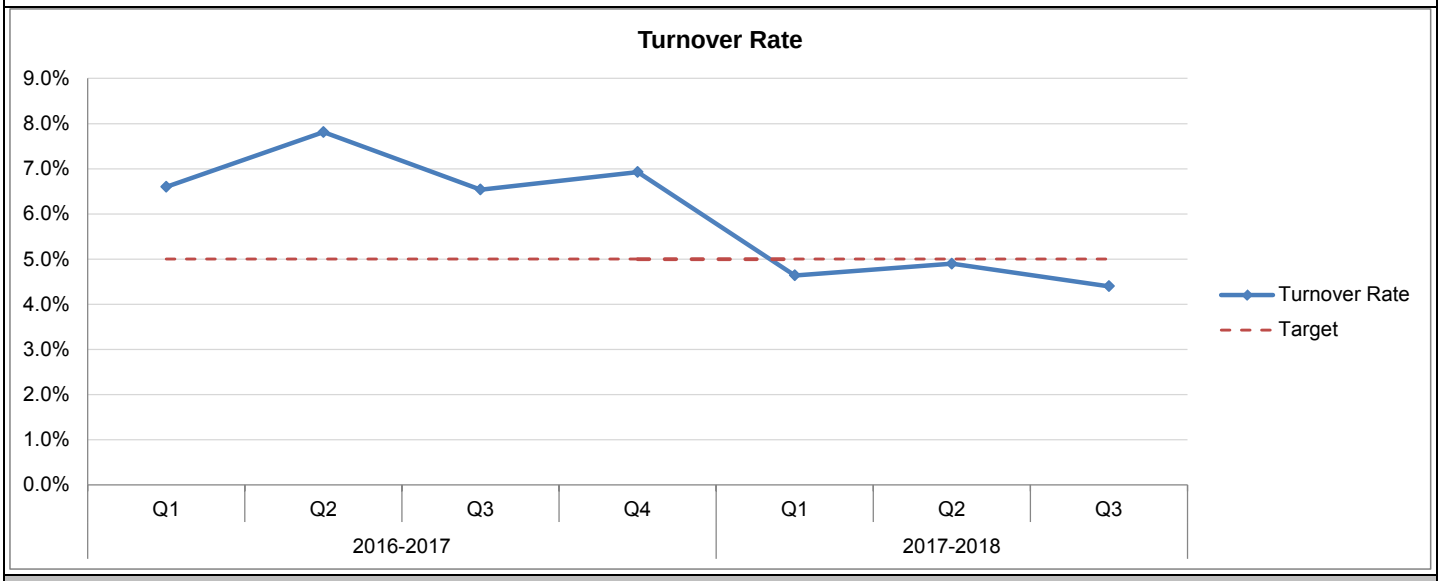
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
4.6%	4.9%	4.4%		4.6%	5.0%	Opportunities for Improvement

Definition

The number of permanent employees that left the employment of Runnymede Healthcare Centre (i.e. voluntary or involuntary) divided by total number of permanent employees.

Significance

A high turnover rate may indicate employee dissatisfaction and the need to determine the root causes with implemention of or changing initiatives and strategies to retain staff.



Analysis

With the completion of the Nursing Redesign turnover rate has returned to below the target. Strategies will need to be developed to maintain the metric within acceptable levels.

Action Plan	Lead	Due Date	Current Status
Develop recruitment and retention strategy	VP, HR & OD	31-Mar-18	In progress
Continue to monitor this indicator.	VP, HR & OD	31-Dec-17	In progress

Name	Signature	Date
Richard Mendonca		03/05/2017

Sick Time Days

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Quarterly	Ontario Hospital Association	Human Resources

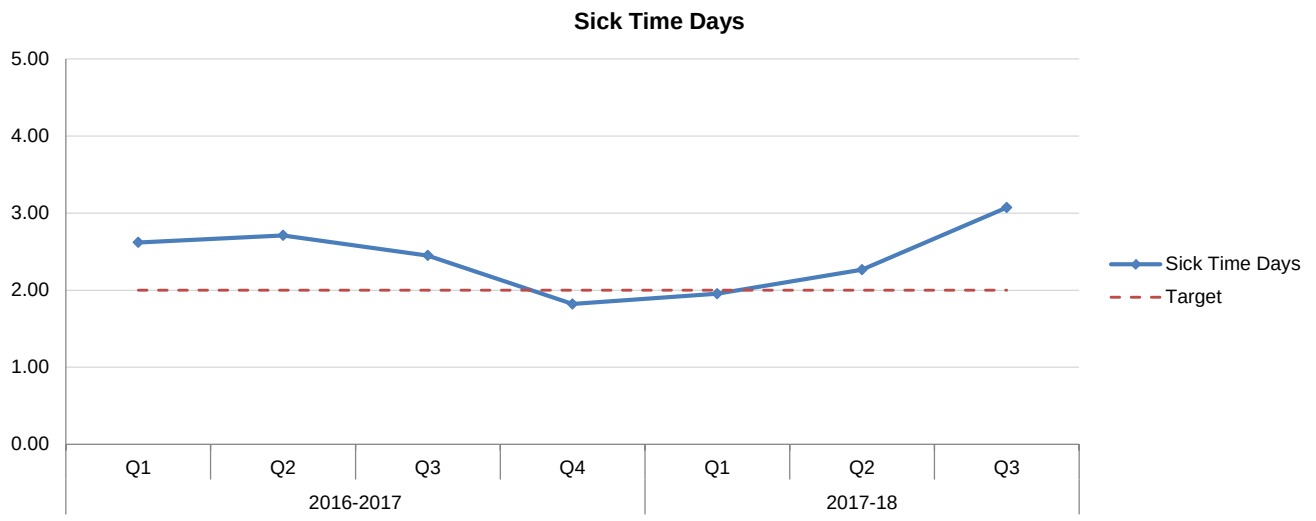
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
1.95	2.27	3.07		2.43	2 days per FT employee per quarter	Opportunities for Improvement

Definition

Average number of sick leave days per full-time (FT) employee per quarter across the organization.

Significance

Benchmark and Target source: OHA HR Benchmark Survey 2013 (10th percentile - best quartile).



Analysis

Sick time day trended up in the last quarter and now underperforms the target. The implementation of the Attendance Management and Support Program has been delayed and the program being amended to align with upcoming changes to employement legislation. Changes to the program are contemplated as a result of changes to employment legislation resulting from the *Employment Standards Act* , 2000. Human Resources is currently revising the program so that adjustment can be implemented once the legislative changes are enacted into law. revised implementation is January 2018

Action Plan	Lead	Due Date	Current Status
Implementation of the attendance management and support is Scheduled for January 2018	VP, HR and OD	30-Jan-18	In progress

Name	Signature	Date

Education as a Percent of Total Expenses

Strategic Direction: YOU FIRST

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Finance and Chief Financial Officer	Quarterly	Internal	Financial Statements

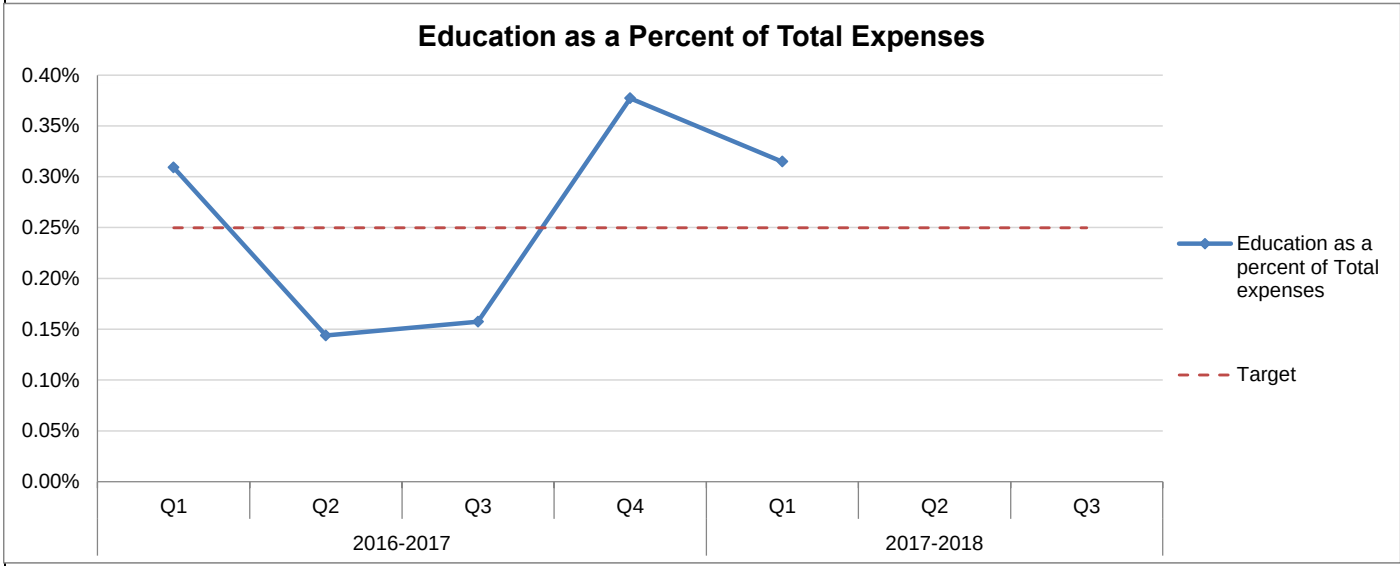
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
0.31%	N/A	N/A		N/A	0.25%	

Definition

This indicator represents the actual expenditure for staff education as a percent of total hospital expenditures.

Significance

Staff education encourages staff to upgrade their skills and keep abreast of newer clinical delivery systems, technology to improve efficiency, and best of class management services.



Analysis

TBD. Current calculation is under review.

Action Plan	Lead	Due Date	Current Status
Continue to budget for appropriate education services and ensure staff are identified for skill training.	VP, Finance & CFO	30-Aug-17	In progress

Name	Signature	Date

Number of Improvement/Process Redesign Projects Initiated to Support Innovations

Strategic Direction: LEAD INNOVATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal	Quality & Risk Management

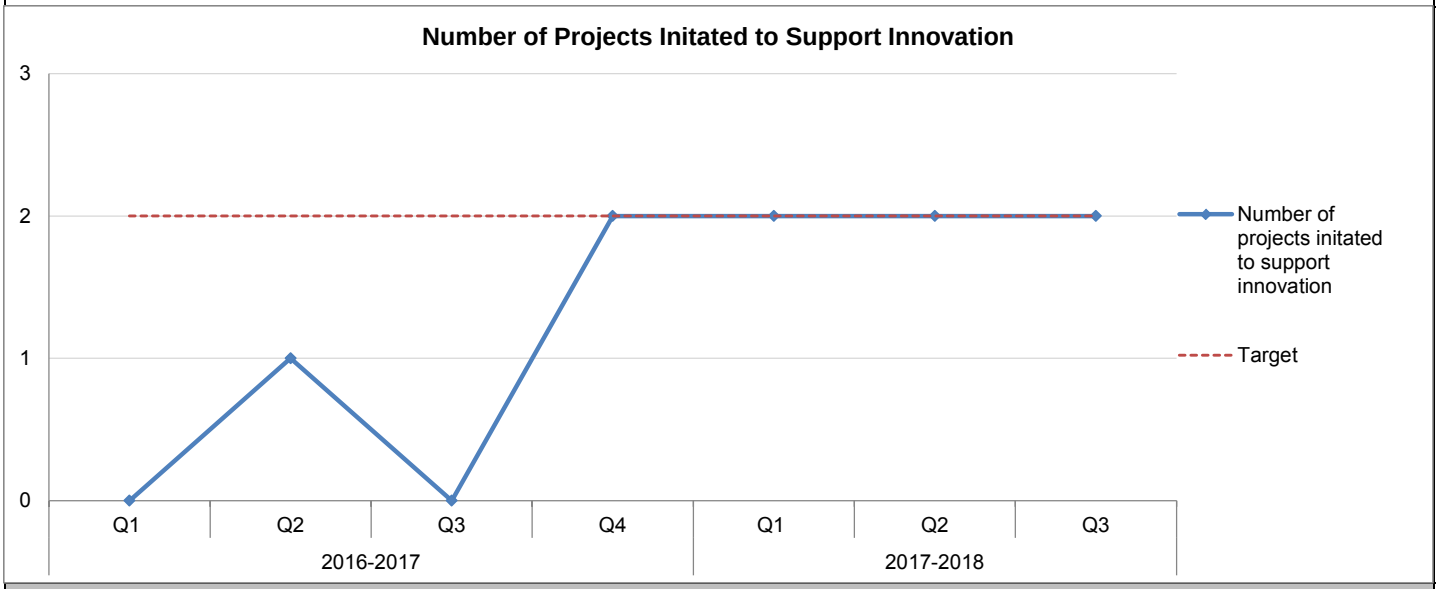
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
2	0	0		2	2 per year	Indicator Meets or Exceeds Performance Target

Definition

Number of new initiatives designed to enhance clinical and/or corporate practice in innovative ways. A hospital wide process improvement project will ensure efficiency and a culture of continuous improvement. The process redesign can be corporate and/or clinical.

Significance

Lead Innovation is an important part of Runnymede's strategic direction, and projects that support innovative care delivery and hospital processes are a fundamental aspect of the hospital's growth and will ensure a culture of continuous improvement.



Analysis

The annual target has been achieved however, ongoing work is to be done to develop capability building strategy related to Lean and continuous quality improvement.

Action Plan	Lead	Due Date	Current Status
Develop corporate capability building strategy related to Lean and continuous quality improvement.	Vice President, Strategy, Quality & Clinical Programs	31-Mar-18	In progress
Implementation of new electronic safety and learning system with enhanced reporting functionality.	Director, Quality & Risk Management	31-Mar-17	Completed
Implementation of new transportation scheduling system.	Manager, Patient Flow	31-May-17	Completed
Optimization of business practices through Lean six sigma tools.	Vice President, Patient Care, Chief Nursing Executive,	31-Mar-18	In progress

Name	Signature	Date

Number of Initiatives Implemented Leveraging Technology to Meet Patient Needs

Strategic Direction: LEAD INNOVATION

Accountability	Reporting Timeline	Reporting Body	Data Source
	Quarterly	Internal	EAC

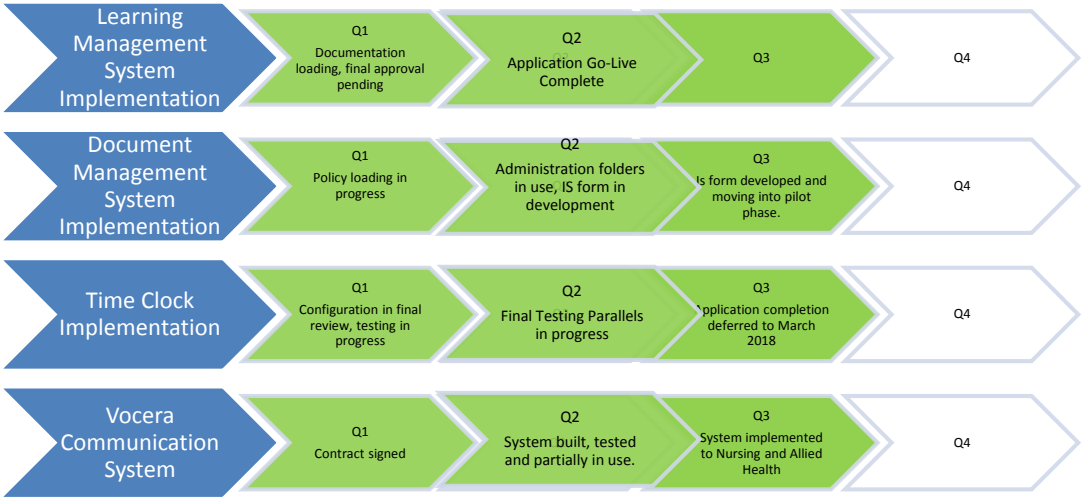
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
0	1	2		3	4 per year	Opportunities for Improvement

Definition

Total number of patient care, care-related processes or business processes affecting patients and families that are modified partially or wholly to introduce and/or leverage technology.

Significance

With the ongoing advancement of technology and the increasing dependence of human beings on it, there is a need to reinvent processes achieving an improved patient experience. Runnymede will henceforth identify and pursue changes in current processes to improve service quality and patient experience through the adoption of technological innovation.



Analysis

Learning Management System - System has now been transitioned to operational and is considered complete.
Document Management System - Boardroom solution awaiting review with CEO. Information Services Equipment Request form in a pilot phase anticipated for rollout by Feb 2018.
Time Clock Implementation - Application is being used by staff although export for Payroll is deferred to March 2018 due to resourcing concerns. Final testing parallels will resume in Feb/March for the end of March export to Payroall.
Vocera Communication System - Solution in use by the Nursing and Allied Health staff. Ancillary departments (House Keeping, Facilities) to start using the solution in February. Communication enhancement for two way communication is going through a procurement process.

Action Plan	Lead	Due Date	Current Status
Learning Management System - Project deliverables complete.	VP Human Resources & OD	Sept 30-17	Completed
Document Management System - Finalize boardroom solution, Information Services Equipment form and start the Finance invoice workflow solution.	VP Finance	Dec 31 2017	Completed
Implementation of time clocks - Application is operationalized from an end user perspective. Further testing and activation planned for payroll export.	VP Finance	Mar 31 2018	In progress
Vocera Communication Systemt - Finalize rollout to ancillary departments. Commence work on two way communication.	VP Patient Care	Dec 31 2017	Completed

Name	Signature	Date

Number of New Strategic Partnerships

Strategic Direction: LEAD INNOVATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clnical Programs	Annual	Internal	Vice President, Strategy, Quality and Clinical Programs

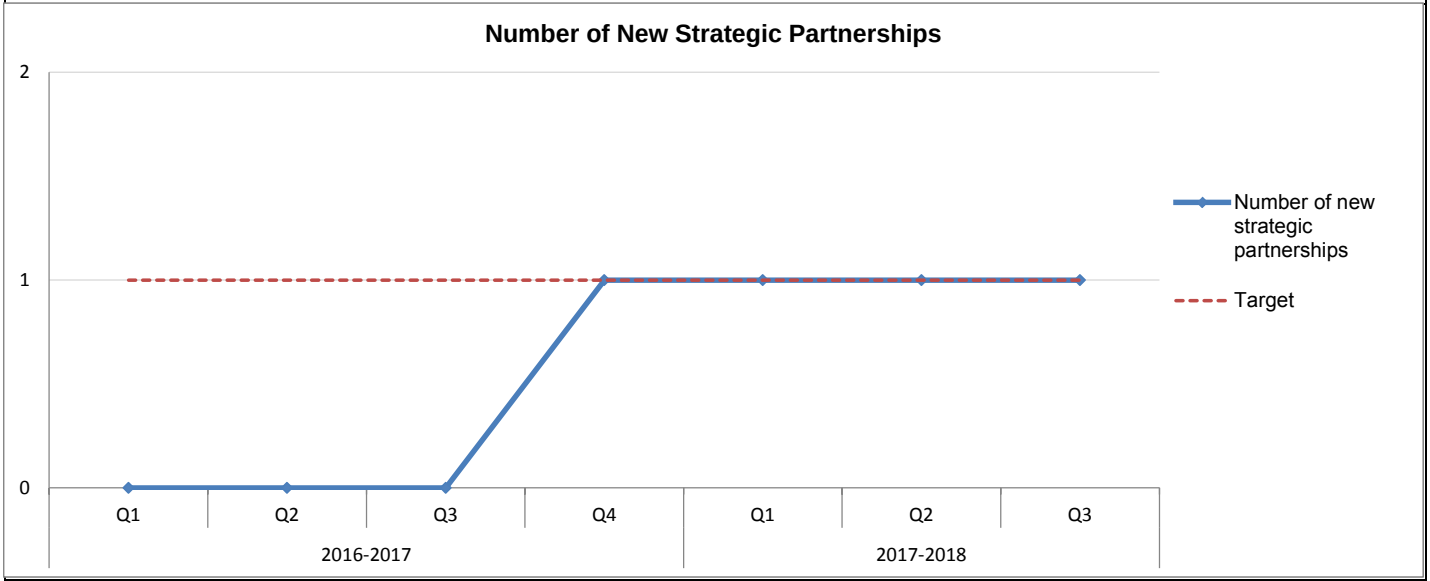
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
1	0	0		1	1 per year	Indicator Meets or Exceeds Performance Target

Definition

Number of external partnerships formed to support Runnymede's strategic directions. This can include pilot programs, collaborations, and other relationships.

Significance

Regardless of the industry, having an ally in the form of a strategy partner will benefit the organization. A strategic partnership will provide Runnymede with competitive advantages and an opportunity to access or provide a broader range of programs and expertise.



Analysis

A feasibility analysis needs to be completed for the rehab program partnership with west end acute care partner.

Action Plan	Lead	Due Date	Current Status
Complete feasibiity analysis for rehab partnership.	VP, Strategy, Quality & Clinical Programs	30-Sep-17	Completed
Complete gap analysis for rehab program.	VP, Strategy, Quality and Clinical Programs	30-Nov-17	Completed
Submit joint rehab proposal to TC LHIN and Mississauga Halton LHIN.	VP, Strategy, Quality and Clinical Programs	31-Dec-17	In Progress

Name	Signature	Date

Percentage of Electronic Medical Record (EMR) Strategy Implemented

Strategic Direction: ACCESS & SUPPORT

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources & Organizational Development	Quarterly		Information Services

Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
					TBD	

Definition

Organizational progress toward the successful implementation of an electronic Medical Record (EMR). A successful implementation will embody the migration of existing and addition of new infrastructure, software, processes, procedures and policies.

Significance

Implement technology including an electronic patient record to support information access and security. It has been demonstrated that technology creates more patient - centric services, while reducing the cost of delivering secure, high-quality care.

Analysis

Consulting firm (Healthtech Consultants) engaged via an RFP process. Anticipated 90 day process to perform an independent analyis of Runnymede's current EMR position and how it aligns with current vendor offerings and the provincial EHR directives.

Action Plan	Lead	Due Date	Current Status
Engaging external consultants to assist with EHR roadmap creation.	VP Finance & CFO	Dec 31 2017	Completed
Ongoing collaboration with Healthtech consultants required for the provision of requested organizational information.	VP Finance & CFO	April 30 2018	In progress
An investigation into automated admission number creations which will also resolve some data quality problem continues.	VP Finance & CFO	March 31 2018	In progress

Name	Signature	Date

Alternate Level of Care (ALC) Rate

Strategic Direction: ACCESS & SUPPORT

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal, Health Quality Ontario	Cancer Care Ontario (CCO)

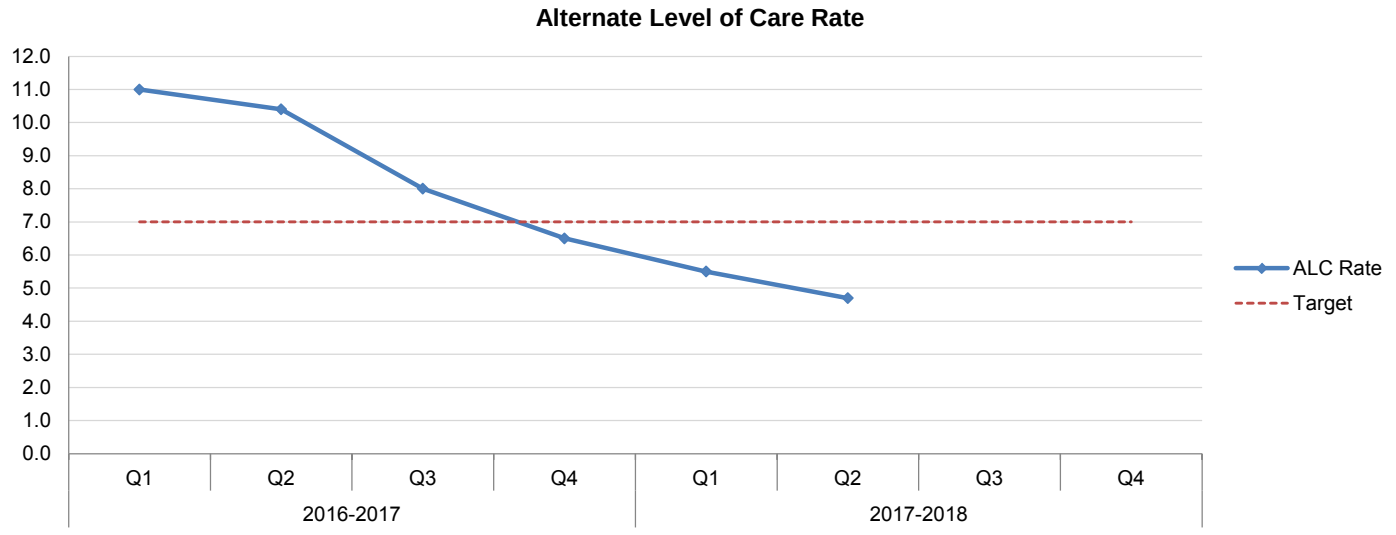
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
5.5	4.7	N/A		5.1	7.0	Indicator Meets or Exceeds Performance Target

Definition

Total number of ALC days in a given time period divided by total number of inpatient days in the same time period. Data is delayed by one quarter.

Significance

ALC avoidance has been identified as a strategic priority for our organization, and is part of our 2016-2017 Quality Improvement Plan, with a target for the ALC rate of 7.0%. The ALC rate indicator represents an accurate count of total ALC days and total patient days for both open and closed cases in a given month, and therefore provides an accurate picture of ALC performance that can be tracked over time.



Analysis

Runnymede's ALC rate continues to exceed our target, indicating successful implementation of our ALC avoidance strategies. With the increase in number of social workers, there has been an increase in follow up with both ALC patients resulting in successful discharges, and in high-risk for ALC patient, where ALC designations have been avoided.

Action Plan	Lead	Due Date	Current Status
Update discharge policy and procedure.	Manager, Access and Flow	31-Mar-17	In progress
Develop a toolkit to communicate discharge planning to patients and families within first 48 hours of admission.	Manager, Access and Flow	31-Mar-17	In progress
Develop brochure for Substitute Decision Makers (SDM) regarding their role in discharge planning.	Manager, Access and Flow	31-Mar-18	Completed
Standardize and strengthen pre-admission screening with referring hospitals.	Manager, Access and Flow	31-Mar-18	In progress
Develop information packet for patients/families outlining discharge destination options e.g. retirement home, long term care and supports to assist transition to community , activity of daily living (ADL) community programs	Manager, Access and Flow	31-Mar-18	Completed
Cohorting ALC patients with focus on long stay patients i.e. greater than 40 days	VP, Strategy, Quality & Clinical Programs	31-Mar-18	In progress

Name	Signature	Date

New Stage 2 to 4 Pressure Ulcer

Strategic Direction:

☑ **You First** ☐ **Lead Innovation** ☐ **Access & Support** ☐ **Supporting Transformation**

Accountability	Reporting Timeline	Reporting Body	Data Source
Director of Nursing	Quarterly	Health Quality Ontario, MAC Quality Committee	CIHI

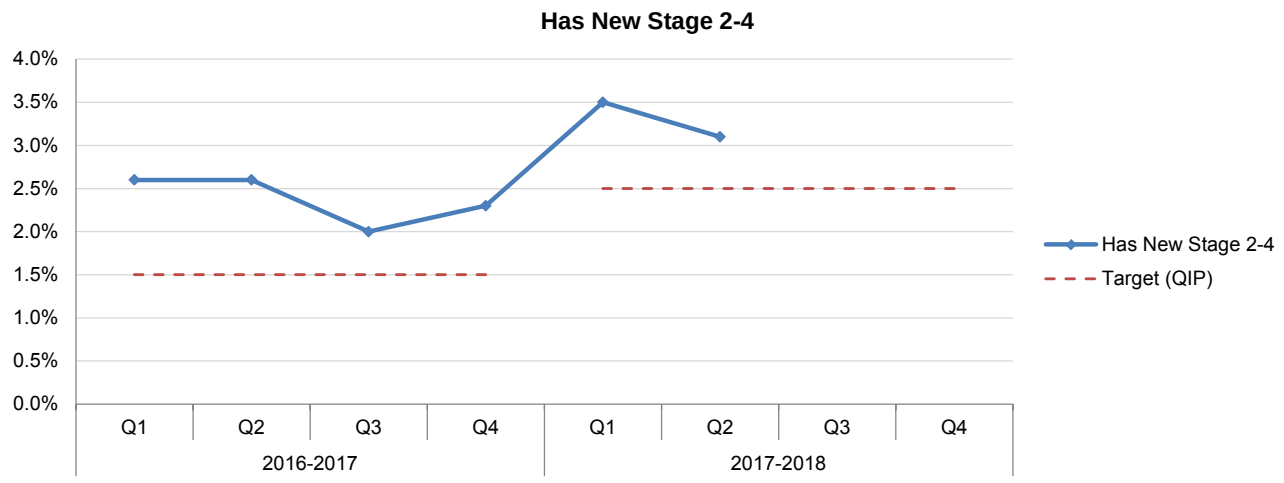
Q1	Q2	Q3	Q4	Year To Date	QIP Target	Indicator Status
3.5%	3.1%	N/A		3.1%	2.5%	Opportunities for Improvement

Definition

Percentage of patients who had a newly occurring pressure ulcer at stages 2 to 4. (Unadjusted Rate)
Numerator - Patients who had a pressure ulcer at stages 2 to 4 on their target assessment and no pressure ulcer at stages 2 to 4 on their prior assessment.
Denominator - Patients with valid assessments, excluding those with stage 2 to 4 ulcers on prior assessment.

Significance

Pressure ulcers occur most commonly in the elderly, which is the fastest-growing segment of the population in healthcare. As a result, the number of patients at risk for developing pressure ulcers is expected to increase dramatically in the coming decades. Given the tremendous burden that pressure ulcers place on the healthcare system (pain, associated risk for serious infection, and increased health care utilization), there is a substantial need for improved prevention methods. Despite the growing emphasis placed on pressure ulcer prevention, pressure ulcers continue to be the most common preventable hospital-acquired condition.



Analysis

Runnymede improved when compared to last quarter, but still not at benchmark. One newly admitted patient with left sided hemiplegia acquired a stage II pressure injury which healed and reopened this quarter. Runnymede will continue to reinforce and encourage staff to educate patients on the necessary prevention of pressure ulcers.

Action Plan

	Lead	Due Date	Current Status
Educate all nursing staff on evidenced-based best practice wound prevention and wound care protocols.	Clinical Educators/APNs	01-Feb-18	In progress
Reinforce importance of daily skin assessment, repositioning patients to offload pressure as per protocol	Clinical Educators/APNs	01-Mar-18	In progress
Revise Skin and Wound Care Program Policy #3M-10	Clinical Educators	01-Jan-18	In progress
Roll out Advanced Practice Nurse Workshop in order to build capacity and sustain the Wound Care Program	Manager Nursing Professinal Practice & Education	01-Oct-17	Completed

Name	Signature	Date

Falls with Harm - Medically Complex

Strategic Direction: ACCESS & SUPPORT

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal, Health Quality Ontario	Safety and Risk Learning System (SRLS)

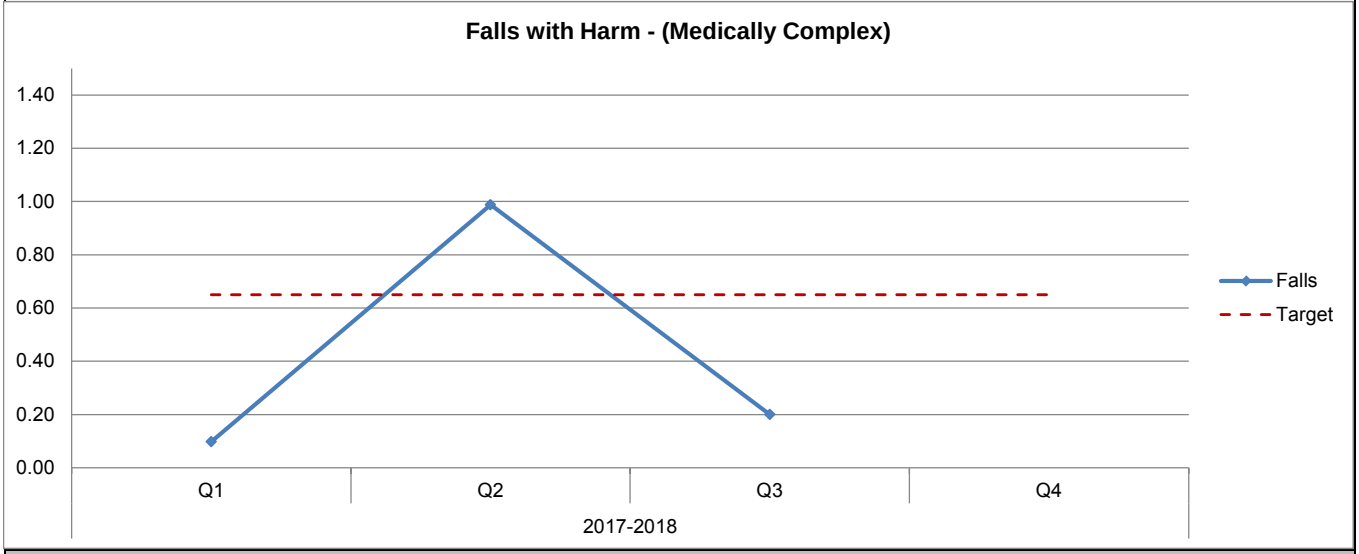
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
0.10	0.99	0.20		0.43	0.65	Indicator Meets or Exceeds Performance Target

Definition

Falls with harm per 1000 patient days/Medically Complex total patient days

Significance

While falls are relatively common for all ages, the likelihood increases with age. The impact of a fall is most severe among those older than age 65 and account for over 85 per cent of all injury-related hospitalizations in this age group. However, many falls can be prevented, and preventive interventions have great potential to reduce the rate and degree of injury from a fall. The goal of rehabilitation is to encourage the fulfillment of personal goals, increase strength and stamina to avoid falls but the path to achieving mobility goals may put patients at an increased risk of falls.



Analysis

Q3 performance of 0.2 outperforms the fiscal year target of 0.65 and shows a significant improvement from 1.00 in Q2. As per Safety and Risk Learning System reporting, 2 falls with harm occurred in the medically complex population. With the implementation of Falls Equipment access & return system on January 17, 2018 and sharing of learnings from the December 2017 Falls compliance audit results with clinical teams, further improvement is expected.

Action Plan	Lead	Due Date	Current Status
Develop process to improve presence of and access to fall prevention equipment e.g. lap tray, chair alarms, floor mats.	Director, Clinical Programs	31-Mar-2018	Completed
Modify the semi-annual falls audit process to ensure resulting data is relevant for program evaluation.	Director, Clinical Programs	31-Mar-2018	Completed
Implement patient safety huddles on each floor focusing on falls prevention	Director, Clinical Programs	30-Nov-2017	Completed
The initiation of hourly purposeful rounding has occurred on all three patient care floors. Long term goal is to measure both compliance and the effect of this intervention through auditing.	Director, Patient Care	Ongoing	In progress

Name	Signature	Date

Falls with harm- Low Tolerance Long Duration

Strategic Direction: ACCESS & SUPPORT

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal, Health Quality Ontario	CCRS

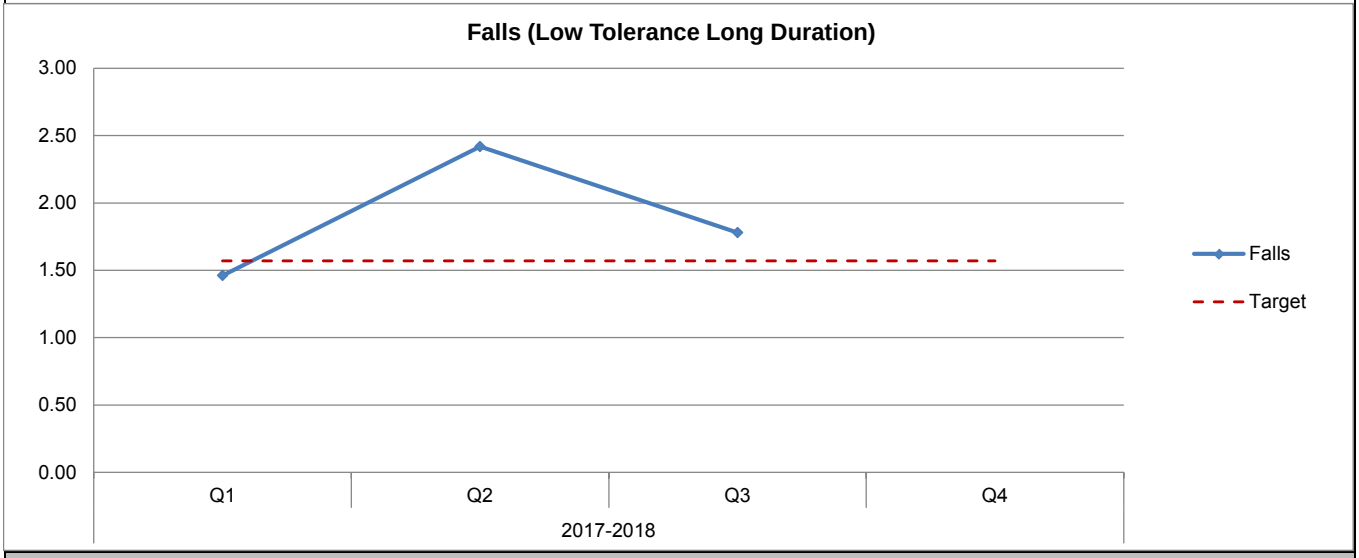
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
1.46	2.42	1.78		1.89	1.57	Opportunities for Improvement

Definition

Falls with harm per 1000 patient days/Low tolerance long duration total patient days.

Significance

While falls are relatively common for all ages, the likelihood increases with age. The impact of a fall is most severe among those older than age 65 and account for over 85 per cent of all injury-related hospitalizations in this age group. However, many falls can be prevented, and preventive interventions have great potential to reduce the rate and degree of injury from a fall. The goal of rehabilitation is to encourage the fulfillment of personal goals, increase strength and stamina to avoid falls but the path to achieving mobility goals may put patients at an increased risk of falls.



Analysis

Q3 score at 1.78 underperforms fiscal year target of 1.57 but has improved from the Q2 score of 2.42. As per Safety and Risk Learning System reporting, 14 falls with harm occurred in the low tolerance long duration population in Q3, an improvement from 19 in Q2. With the implementation of Falls equipment Access and Return system on January 17, 2018 and sharing of learnings with clinical teams from Dec. 2017 Falls compliance audit, further improvement in score is expected.

Action Plan	Lead	Due Date	Current Status
Develop process to improve presence of and access to fall prevention equipment e.g. lap tray, chair alarms, floor mats.	Director, Clinical Programs	31-Mar-2018	Completed
Modify the semi-annual falls audit process to ensure resulting data is relevant for program evaluation.	Director, Clinical Programs	31-Mar-2018	Completed
Implement patient safety huddles on each floor focusing on falls prevention.	Director, Clinical Programs	30-Nov-2017	Completed
The initiation of hourly purposeful rounding has occurred on all three patient care floors. Long term goal is to measure both compliance and the effect of this intervention through auditing.	Director, Patient Care	Ongoing	In progress

Name	Signature	Date

Emergency Department (ED) Transfer Rate

Strategic Direction: Access & Support

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Patient Care, Chief Nursing Executive & Chief Privacy Officer	Quarterly	Internal	Health Information Services

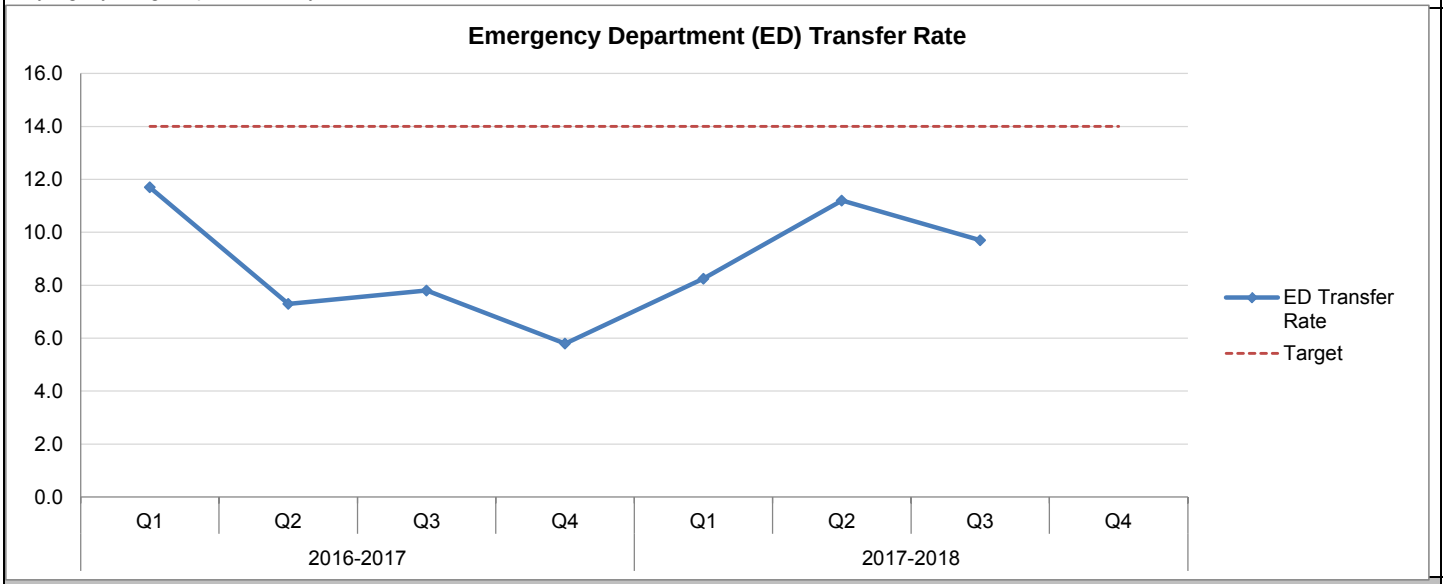
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
8.3	11.2	9.7		9.7	14.0	Indicator Meets or Exceeds Performance Target

Definition

The number of patients transferred to the emergency department for a modified list of ambulatory care-sensitive conditions per 100 patient beds.
Excludes: planned or scheduled ED visits.

Significance

ED visits can be necessary and appropriate. Tracking ED visits for certain specific conditions can help identify ED transfers that could have been avoided if the underlying cause was effectively managed earlier. Reducing the number of patients transferred to acute care improves the patient experience by reducing the number of transitions, while reducing the overall burden on the health care system. A higher number of transfers to the emergency department may signify a higher patient acuity level.



Analysis

Runnymede's potentially avoidable ED transfers decreased over the last quarter and continues to outperform the target. There were 20 transfers to the Emergency Department in Q3 meeting the definition. Chart reviews indicate that 16 (80%) of these transfers were related to infectious disease processes (5 cases of pneumonia, 7 cases of Urinary Tract Infections, 3 cases of septicemia and 1 case of cellulitis) and 3 (15%) were related to falls (fractures or significant injury).

Action Plan	Lead	Due Date	Current Status
Establish weekly floor based wound rounds to identify patients that may be at risk for septicemia.	Associate Director of Nursing	30-Mar-17	Completed
Improve the process for periodic review of Advanced Care Directives to ensure patients receive appropriate medical interventions to prevent a preventable ED	Associate Director of Nursing	31-Mar-18	In progress
Evaluation of pneumonia cases to establish interventions that may reduce avoidable ED transfers.	Associate Director of Nursing	30-Dec-17	Completed
Oral Hygiene indicators incorporated in Nursing Practice Audit to understand the baseline for compliance from frontline staff to determine education deficit.	Associate Director of Nursing	30-Mar-18	Completed
Develop education program for frontline staff on Oral Hygiene assessment and management.	Clinical Educators/Speech Language Pathologists	31-Jul-18	In progress

Name	Signature	Date

Number of new community partnerships

Strategic Direction: ACCESS & SUPPORT

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Strategy, Quality and Clinical Programs	Quarterly	Internal	Communications

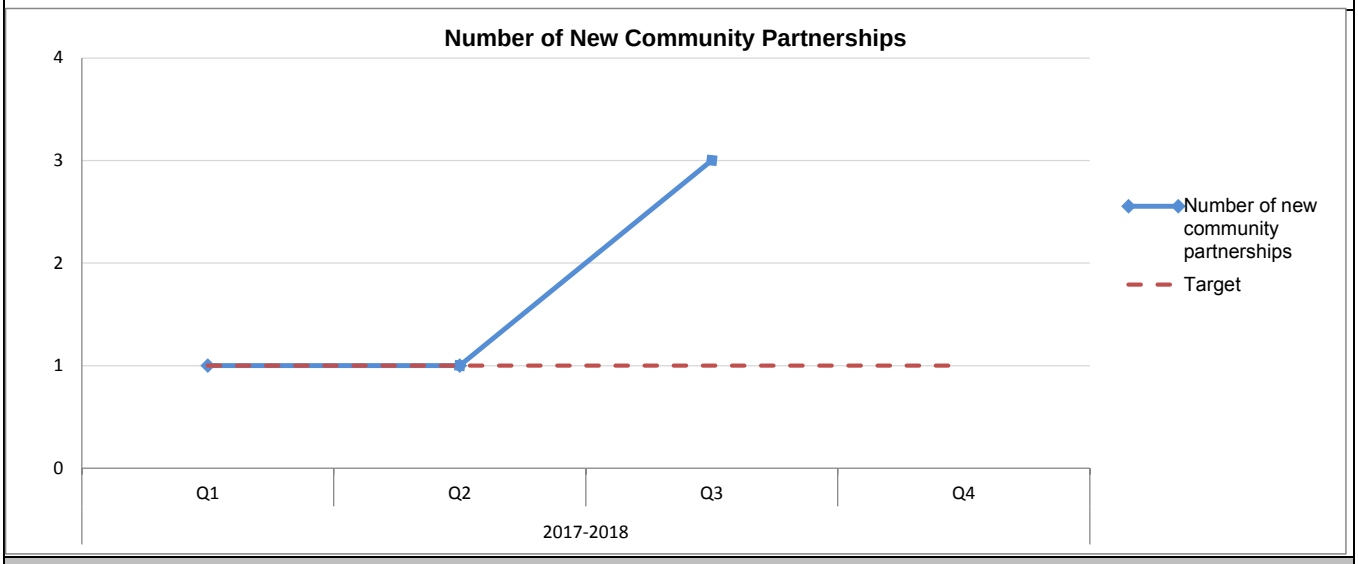
Q1	Q2	Q3	Q4	Year to Date	Target	Indicator Status
1	1	3		5	1 per year	Indicator Meets or Exceeds Performance Target

Definition

Number of partnerships that engage the community in the development and implementation of initiatives that align with our mission and vision, address the needs of our community and support our overall success.

Significance

Engaging our community through new and innovative means will ensure our commitment to serve and address their needs.



Analysis

We have currently exceeded the annual target.

Action Plan	Lead	Due Date	Current Status
Participate in St Joe's Communicaty Senior's Forum and panel discussion	Director, Communications	27-Jun-17	Completed
Participate in Syme 55 Health Fair	Director, Communications	29-Sep-17	Completed
Partner with Ontario Society of Senior Citizens Organizations to participate in their ann	Director, Communications	7-Nov-17	Completed
Develop a speaker series targetted to the local community	Director, Communications	31-Mar-18	Completed
Hold first speaker session with 2 community organizations	Director, Communications	5-Dec-17	Completed
Participate in Eglinton Hill Centre Active Living Fair for seniors.	Director, Communications	1-Mar-18	In progress
Participate in VRx research study	Director, Communications	31-Mar-18	In progress
Hold first speaker session with patient families	Director, Communications	31-Mar-18	In progress

Name	Signature	Date

Total Waste Generation Reduction

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Quarterly	Internal	Wasteco

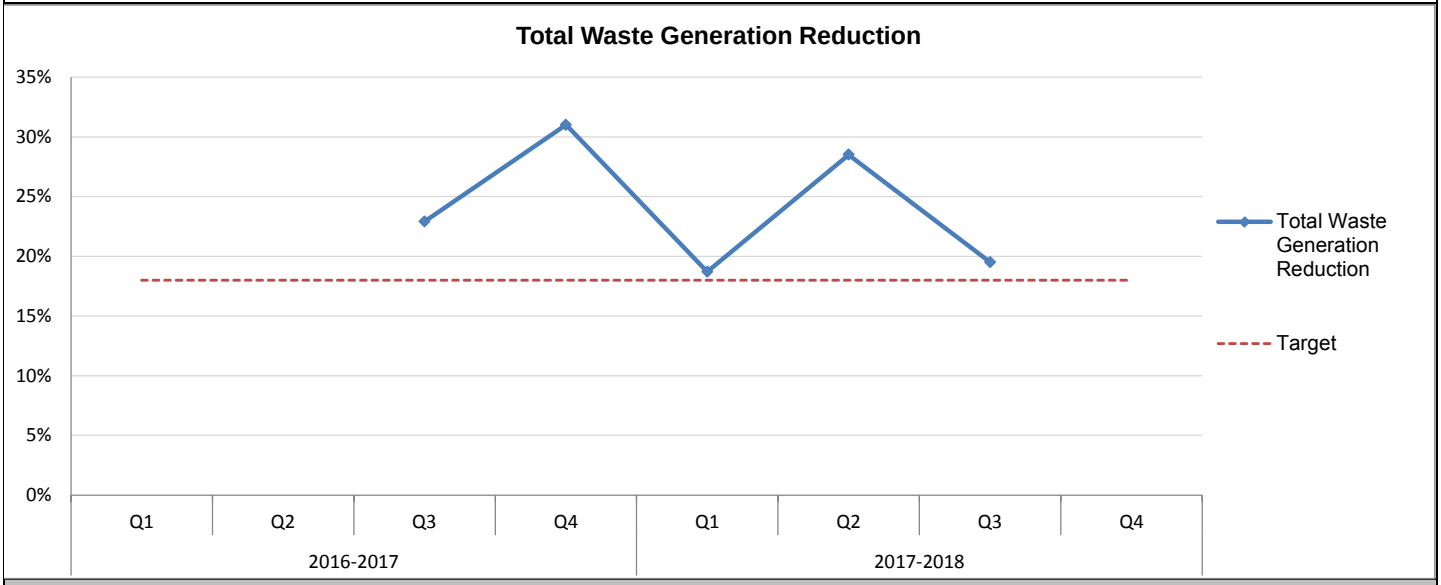
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
18.7%	28.5%	19.5%		20.6%	18.0%	Indicator Meets or Exceeds Performance Target

Definition

Total waste generation reduction is the process of reducing the amount of waste generated from within the facillity. For example, composting, or using recyclable products as opposed to products which go directly to landfill. The rate is calculated by the amount of waste diverted against the total amount of waste produced by the facility.

Significance

In 2016, approximately 275 tonnes of waste was produced. By reaching our target of 18% waste generation will be reduced by almost 50 tonnes annually. This will allow Runnymede to reduce its impact on the environment.



Analysis

Approximately 16 tonnes of waste was diverted in Quarter 2 (19.5%). Higher rates of recycling has brought this rate above our target for this quarter.

Action Plan	Lead	Due Date	Current Status
Waste Audit to be conducted through Wasteco.	Manager of Facilties and Environmental Sustainability	31-Mar-18	In progress

Name	Signature	Date

Waste Diversion Rate to Recycling

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Quarterly	Internal	Wasteco, Stericycle, Revolution Recycling

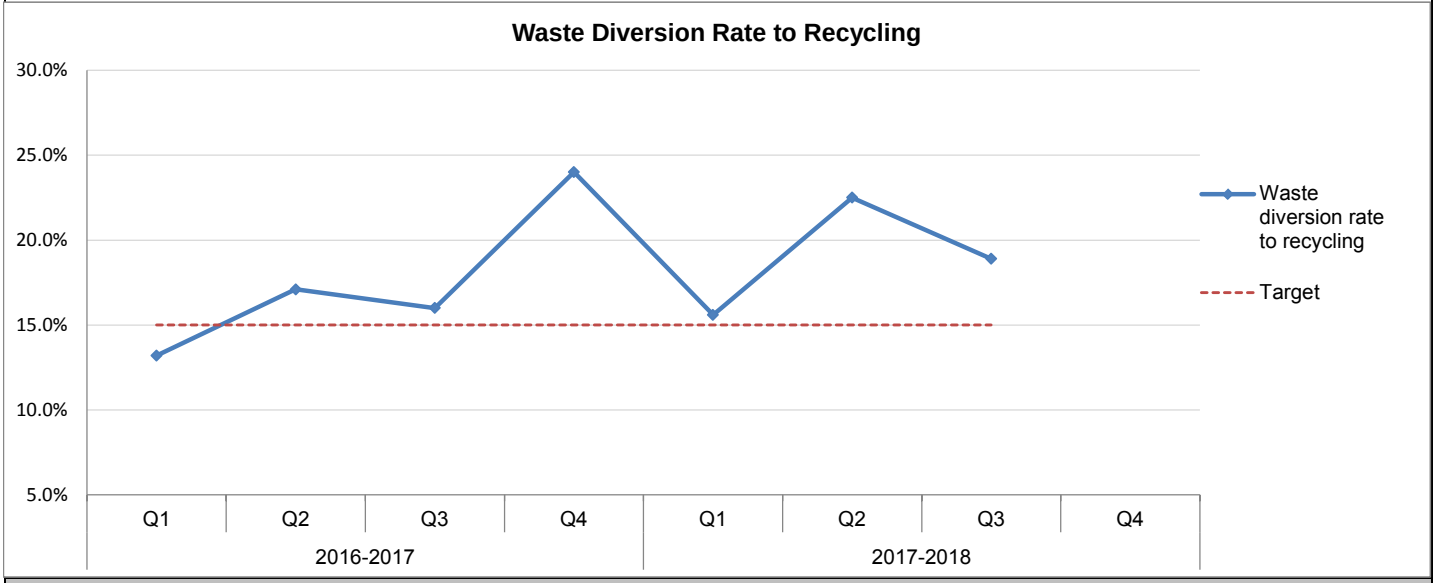
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
15.6%	22.5%	18.9%		18.9%	15.0%	Indicator Meets or Exceeds Performance Target

Definition

Waste diversion rate to recycling is the process of diverting waste from landfills through the recycling of plastic, cardboard/paper products and e-waste. This is caclulated by the total weight of recycling against the total waste collected including recyclable materials.

Significance

In 2016, approximately 275 tonnes of waste was produced. Based on the projection of 15%, approximately 42 tonnes can be diverted from landfills through our recycling programs which significantly contribute to our commitment to environmental sustainabilty.



Analysis

We have recycled approximately 15.5 tonnes of material in Quarter 3 (18.9%). A large amount of obsolete hosptial equipment was recycled and dontated, which brought our recycling rates well above our target.

Action Plan	Lead	Due Date	Current Status
Improved outdoor waste bin recycling.	Manager, Facilties and Environmental Sustainability	31-Mar-18	In progress

Name	Signature	Date

Total Margin

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Finance and Chief Financial Officer	Quarterly	MOHLTC	Runnymede General Ledger

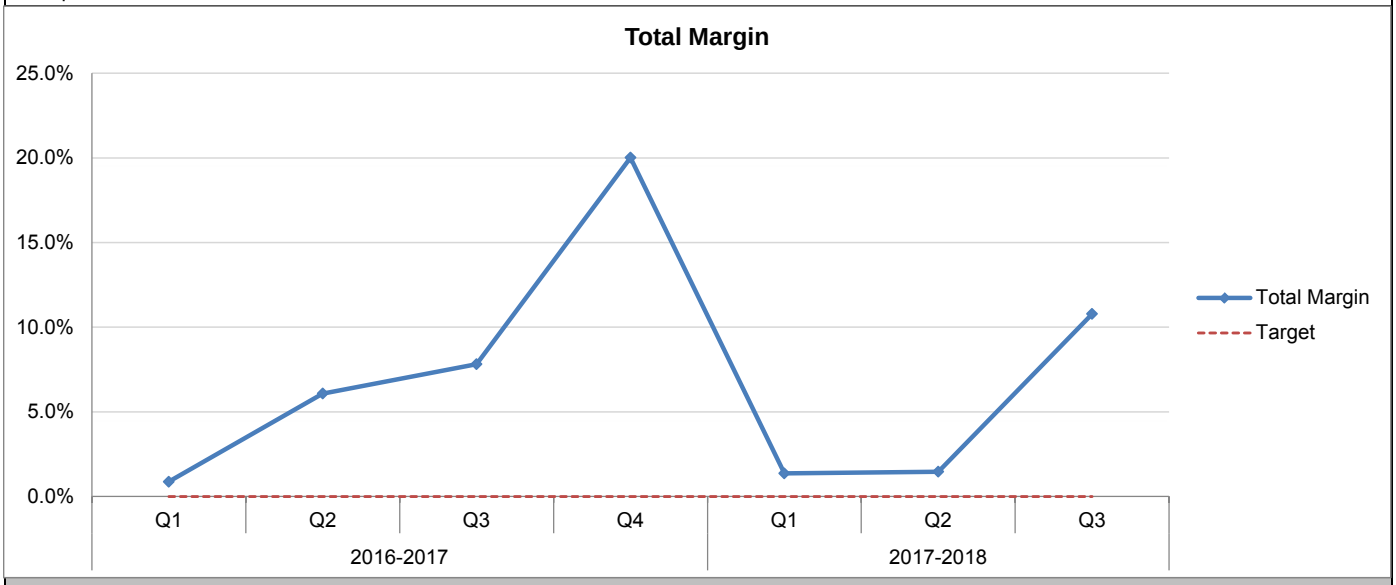
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
1.36%	1.46%	10.78%		10.78%	0.00%	Indicator Meets or Exceeds Performance Target

Definition

Percent by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expenses, excluding the impact of building amortization and deferred capital contributions.

Significance

Financial effectiveness and viability reflects the hospital's ability to operate within funding/revenues earned. This indicates that there is operational efficiency, ensuring that there are sufficient resources required to support hospital operations, purchase necessary equipment and maintain the building as required.



Analysis

Q3 total margin is in-line with typical operations for the quarter. The reduction from the prior quarter is due to the previous reversal of deferred revenues related to HBAM (Health-Based Allocation Model) funding.

Action Plan	Lead	Due Date	Current Status
No further actions required.			

Name	Signature	Date

Current Ratio

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Finance and Chief Financial Officer	Quarterly	MOHLTC	Runnymede General Ledger

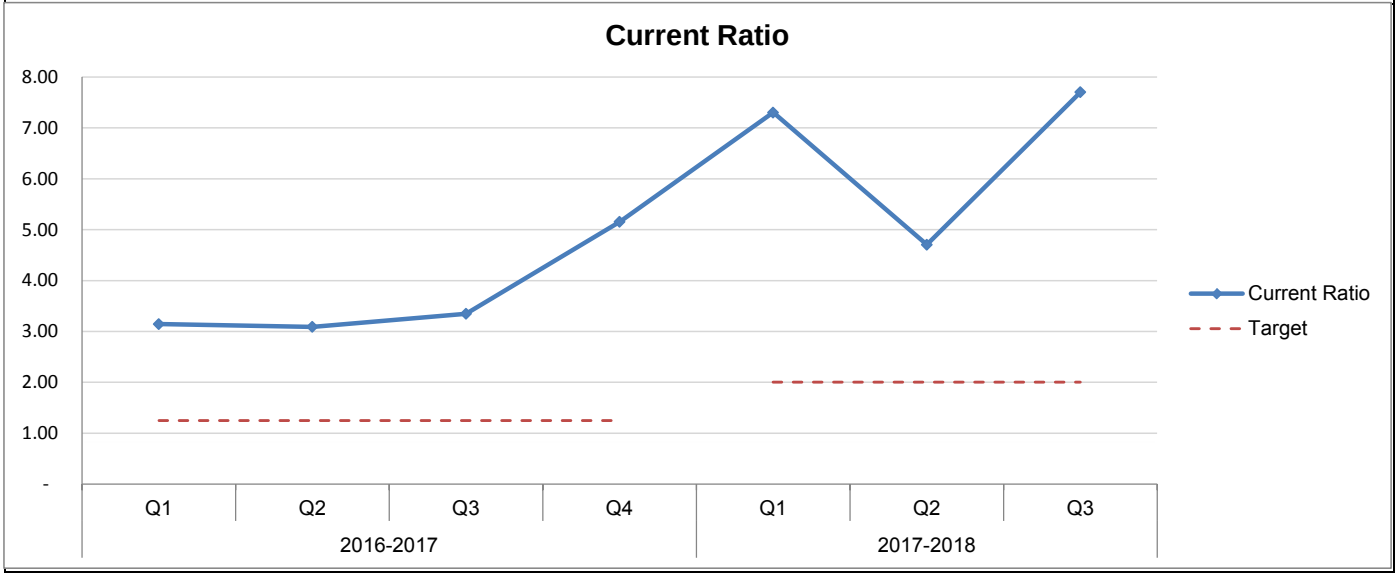
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
7.30	4.70	7.70		7.70	2.00	Indicator Meets or Exceeds Performance Target

Definition

Current Assets ÷ Current Liabilities. The number of times a hospital's short term obligations can be paid using the hospital's short term assets.

Significance

The Hospital's ability to pay current liabilities including staff salaries and wages which comprise of approximately 75% of expenses allows management to focus on operational excellence/quality care for our patients and community.



Analysis

Current ratio continues to improve as the result of positive financial operating performance and increases in portofolio investments. The variance between Q2 and Q3 is due to the timing of MOHLTC revenue recognition

Action Plan	Lead	Due Date	Current Status
Maintain current performance.	VP, Finance & CFO		Completed

Name	Signature	Date

Percentage of non-Ministry of Health and Long-Term Care Revenue

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Finance and Chief Financial Officer	Quarterly	MOHLTC	Runnymede General Ledger

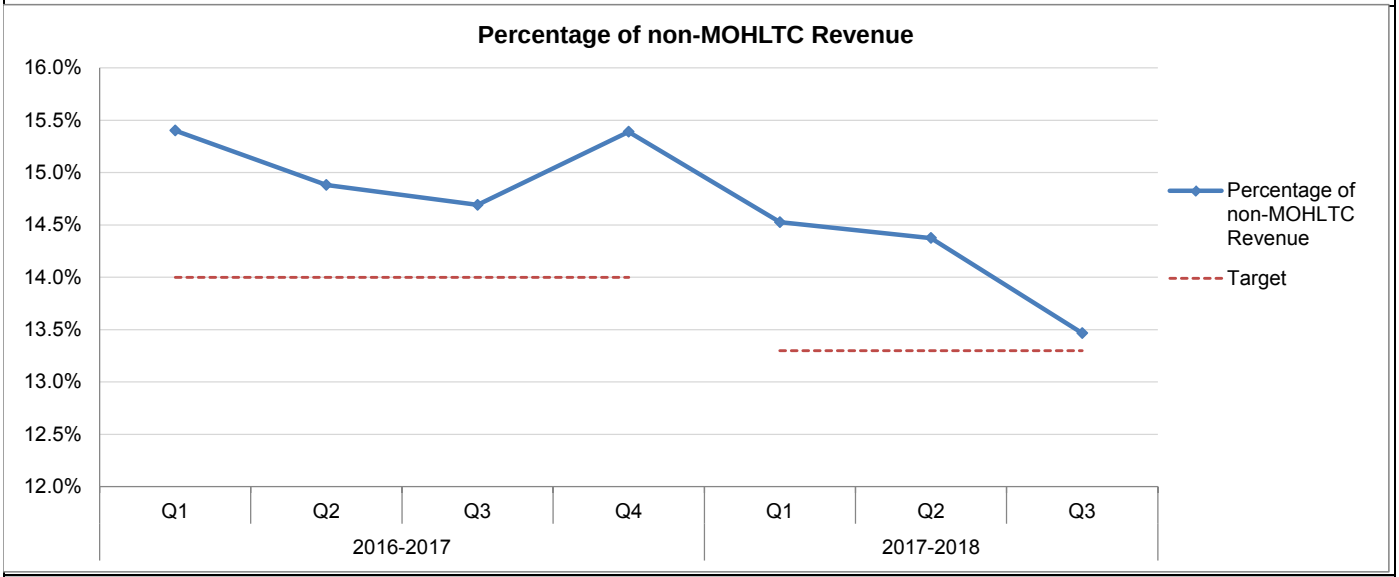
Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
14.5%	14.4%	13.5%		13.5%	13.3%	Opportunities for Improvement

Definition

Total revenue earned from all other sources i.e. not derived from Ministry Of Health and Long Term Care (MoHLTC), divided by total revenue.

Significance

Growth of MOHLTC revenue is limited. Revenue has not kept pace with inflation and other operating expense pressures. Hospitals must seek out alternative ways to maximize and generate alternate revenue streams



Analysis

There is a general decrease in co-payment related to changes in the formula used to calculate personal income. In addition, private and semi-private revenues are also lower than the same quarter last year.

Action Plan	Lead	Due Date	Current Status
Maintain current performance.	VP, Finance & CFO		Completed

Name	Signature	Date

Employee Performance Evaluation Completion Rate

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Quarterly	Internal	Human Resources

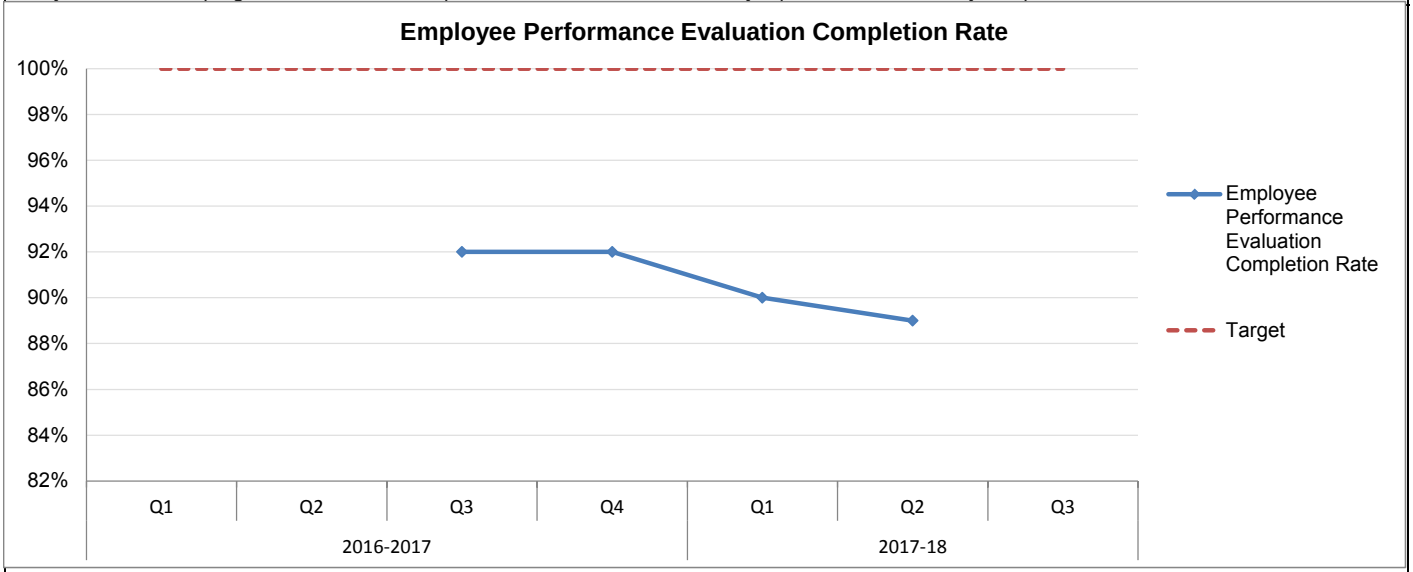
Q1	Q2	Q3	Q4	YTD	Target	Indicator Status
90%	89%	N/A		90%	100%	Opportunities for Improvement

Definition

A performance management strategy is a set of ongoing management practices that help ensure employees get the direction, feedback, and development they need to succeed in their roles. All permanent full-time and permanent part-time employees are included in calculating the completion rate. In the first cycle of the new performance management strategy, the goal of "Improving Patient Experience" will be the focus of measuring effective performance.

Significance

A performance management system aligns individuals with organizational goals, provides insight as to which employees should be rewarded and which skills could be improved as well as making sound decisions regarding people and resources. Runnymede Healthcare Centre's performance review and salary administration program will maintain compensation levels that are internally equitable and externally competitive.



Analysis

Managers have identifed that the paper system has presented some challenges in completing all of the required evaluations in a timely manner. The challenge is highlighted in this first quarter where goal setting also occurs. The majority of outstanding evaluations were completed after the deadline and will be captured in the next quarterly report. Human Resources has dertermined that moving to an electronic system will improve timely completion.

Action Plan	Lead	Due Date	Current Status
Implement electronic performance management system	VP, HR & OD	31-Dec-17	In progress

Name	Signature	Date
Richard Mendonca		30/05/2017

Percentage of Individual Accountability Plans Completed for Leadership Team

Strategic Direction: SUPPORTING TRANSFORMATION

Accountability	Reporting Timeline	Reporting Body	Data Source
Vice President, Human Resources and Organizational Development	Quarterly		Human Resources

Q1	Q2	Q3	Q4	Year To Date	Target	Indicator Status
					100%	

Definition

Significance

Analysis

Action Plan	Lead	Due Date	Current Status

Name	Signature	Date