

fiscal
2025-2026 **Q4**
4th quarter ended March 31, 2026

KHSCthis



Strategy Performance Report



Hôpital
Hotel Dieu
Hospital



Hôpital Général de
Kingston General
Hospital

Kingston Health
Sciences Centre

Centre des sciences de
la santé de Kingston

KHSC Strategy Performance Report Fiscal 2026

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Outcome: Foster a culture of teaching, learning, research and scholarship

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Q4 FY2026 Strategy Performance Indicators Report

Strategic Direction	Goal	Indicator	25-Q4	26-Q1	26-Q2	26-Q3	26-Q4
1. Ensure quality in every patient experience	a. Make quality the foundation of everything we do	Adoption KPI 1: Barcode Medication Administration (BCMA) is adopted successfully and meets Oracle Health's defined average target	Y	G	G	G	G
		Adoption KPI 2: Computer Provider Order Entry (CPOE) is adopted successfully and meets Oracle Health's defined average target	G	G	G	G	G
		Be compliant with the ROPs and high priority standards by meeting the quarterly targets as identified in KHSC QIP FY 2026 (Y/N)	N/A	G	G	G	G
		Plans to manage approved budget and improve deficit towards a break-even operating position are in place Y/N	G	G	G	G	G
	b. Ensure smooth transitions in care for patients and families across our regional health care system	Percentage of eligible patients from the existing roster and the OHaH successfully transitioned into LP model, and new home care patients accepted into the LP	N/A	G	G	G	G
		Urgent home care cases addressed within 24 hours for Loyalist FHT patients	N/A	G	G	G	G
		At least 2 clinics for both CHF and COPD offered monthly in Kingston or Napanee (24 clinics per year)	N/A	G	G	G	G
	c. Lead the evolution of people-centred care	12 patient stories which highlight the patient experience including, where appropriate, KHSC's response to their unique equity considerations	N/A	G	G	G	G
	d. Create the space for better care	Plans for addressing short-term, urgent patient-care facility needs are meeting quarterly milestones Y/N	G	G	G	G	G
2. Nurture our passion for caring, leading and learning	a. Foster a safe, healthy, innovative working environment that inspires and motivates the people who work, learn and volunteer at KHSC	Percentage of team-level Psychological Health and Safety risk assessments completed (inclusive of workplace violence-related risks)	N/A	Y	Y	G	G
	b. Empower and develop our people	Number of cross-training events that take place	G	G	G	G	G
	c. Develop confident, caring and capable leaders	Launch leadership readiness program (Y/N)	N/A	G	G	G	G
3. Improve the health of our communities through partnership and innovation	a. Be a hospital beyond our walls that delivers complex, acute and specialty care where and when it is needed most	KHSC participates in Ministry-directed OHT initiatives Y/N	G	G	G	G	G

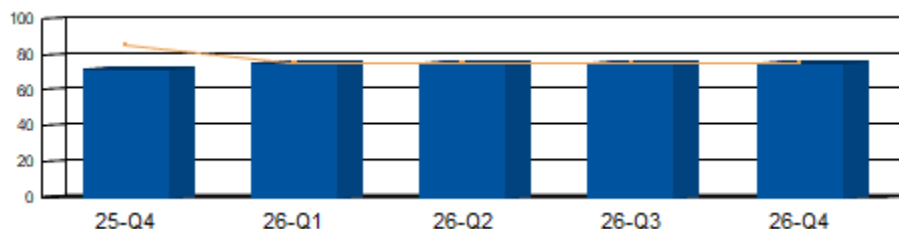
			25-Q4	26-Q1	26-Q2	26-Q3	26-Q4
		Evidence of effective identification, submission, and advocacy for critical break/fix and optimization needs at the regional level, and evidence of execution of agreed-upon plans	N/A	G	G	G	G
		KHSC informatics team and Lumeo operational governance structure in place	N/A	G	G	G	G
	b. Discover and apply innovations that improve patient outcomes and make our communities healthy	Approved plan for CAR T-cell therapy is in place (Y/N)	N/A	G	G	G	G
4. Launch KHSC as a leading centre for research and education	a. Foster a culture of teaching, learning, research and scholarship	KHSC achieves 80% of total placement requests (Y/N)	N/A	G	G	G	G
		Implementation project meets quarterly milestones (Y/N)	N/A	G	G	G	G
5. Advance equity, inclusion, and diversity and address racism to achieve better outcomes for patient families.	a. Create an inclusive environment for patients, families and everyone who works, learns and volunteers at KHSC	Percentage of current KHSC employees who have completed foundational inclusion training	N/A	G	G	G	G

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

a. Make quality the foundation of everything we do

Indicator: Adoption KPI 1: Barcode Medication Administration (BCMA) is adopted successfully and meets Oracle Health's defined average target



	Actual	Target
25-Q4	72	85
26-Q1	75	75
26-Q2	75	75
26-Q3	75	75
26-Q4	75	75

Describe the tactic(s) we are implementing to achieve this objective:

Monitoring of adoption continues on BCMA workflows. Targeted interventions at the unit and/or user level are orchestrated when compliance data show areas of low compliance. KHSC clinical leadership have access to this KPI data and are able to see their unit's performance in comparison to other areas and support remediation initiatives. The Clinical Informatics team, particularly the training team, supports unit leadership and the professional practice team in delivering re-education and remediation initiatives at unit-level.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Q4 data showed an average of 75.4% conformance with BCMA, trending slightly up from last quarter. Troubleshooting of clinical workflow or technical related issues that can impact this KPI continues across the organization. Following the remediation initiative in the Emergency department in Q3, Q4 was spent monitoring for improvement in BCMA compliance rates within this area.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes. Continued monitoring across all units continues with more involvement of clinical leaders by unit becoming increasingly more involved in unit-level auditing.

Definition: EVP - Hann
MRP - Achim
REPORTING COMMITTEE - Patient Care & Quality Committee

Target: Target 25/26: 75% Perf. Corridor: Red BCMA : < 55%, Yellow BCMA: 55 - 74 %, Green BCMA : 75% or above

Prior Targets:

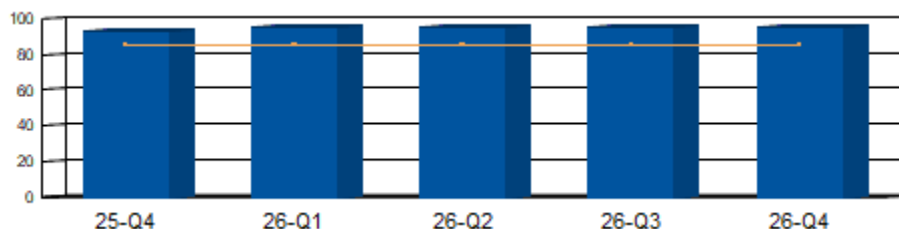
Target 24/25: 85% Perf. Corridor: Red BCMA : < 65%, Yellow BCMA: 65 - 84 %, Green BCMA : 85% or above

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

a. Make quality the foundation of everything we do

Indicator: Adoption KPI 2: Computer Provider Order Entry (CPOE) is adopted successfully and meets Oracle Health's defined average target



	Actual	Target
25-Q4	93	85
26-Q1	95	85
26-Q2	95	85
26-Q3	95	85
26-Q4	95	85

Describe the tactic(s) we are implementing to achieve this objective:

Monitoring of adoption continues for CPOE workflows. Targeted interventions at the user level is orchestrated. With the assistance of the CMIO, Clinical Informatics team, particularly the training team, targeted remediation initiatives are conducted. The Medical Informatics Council is also leveraged to provide re-education or highlight deviation from approved workflows and to course correct.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Q4 data showed an average of 95.3% conformance with CPOE. KHSC continues to perform strongly on this indicator since go-live. Targeted troubleshooting when workflow challenges arise are undertaken to ensure continued adoption of the RHIS and electronic order entry workflows.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes. Continued monitoring and targeted remediation initiatives are ongoing.

Definition: EVP - Hann
MRP - Achim
REPORTING COMMITTEE - Patient Care & Quality Committee

Target: Target 25/26: 85% Perf. Corridor: Red BCMA : < 65%, Yellow BCMA: 65 - 84 %, Green BCMA : 85% or above

Prior Targets:

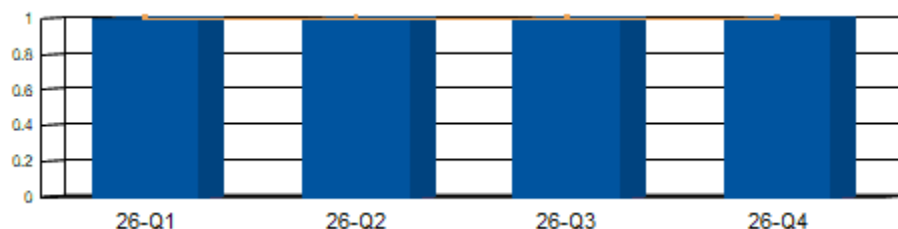
Target 24/25: 85% Perf. Corridor: Red BCMA : < 65%, Yellow BCMA: 65 - 84 %, Green BCMA : 85% or above

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

a. Make quality the foundation of everything we do

Indicator: Be compliant with the ROPs and high priority standards by meeting the quarterly targets as identified in KHSC QIP FY 2026 (Y/N)



	Actual	Target
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

Progress is underway to meet the ROPs and HPs. Unmet ROPs are related to ensuring there is sufficient alignment between TCU and KHSC practices to meet the requirement for Tests of compliance.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

ROP - 100% and HP - 100%

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Met - the target for this indicator was met

Definition: EVP - Fitzpatrick
MRP - Dave
REPORTING COMMITTEE - Patient Care & Quality Committee

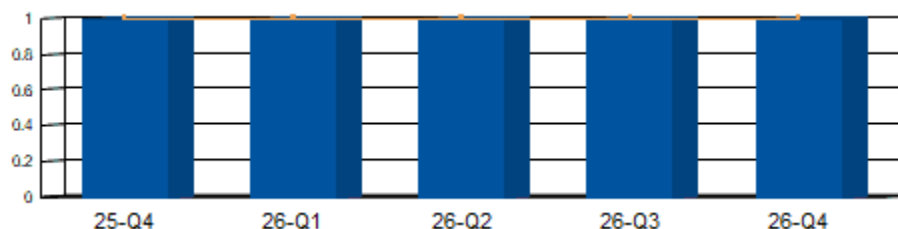
Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress, Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

a. Make quality the foundation of everything we do

Indicator: Plans to manage approved budget and improve deficit towards a break-even operating position are in place Y/N



	Actual	Target
25-Q4	1	1
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

The plans in place were part of a financial sustainability focus with all of hospital leadership participating and encompassed a number of drivers of efficiency including reduction of agency staff with associated accommodation costs, reduction in overtime hours worked and supply efficiencies, combined with additional Ministry of Health funding that was not anticipated at the time of the budget preparation.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

The year end financial results were a corporate deficit of \$38.0M compared to a budgeted deficit of \$49.7M. At the Hospital Sector Accountability Agreement level the budgeted deficit was \$48.0M and the year end deficit was \$33.8M.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes.

Definition: EVP - Toop
MRP - Toop
REPORTING COMMITTEE - People, Finance & Audit Committee

Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Prior Targets:

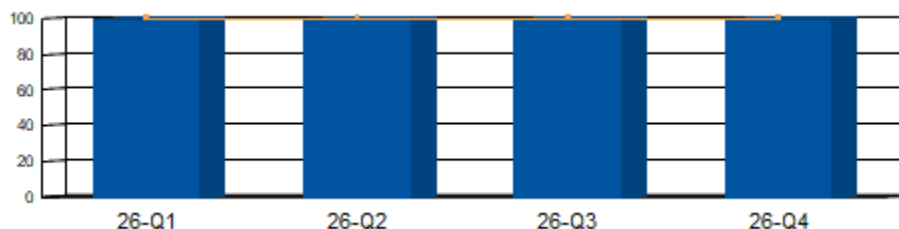
Target 24/25: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

b. Ensure smooth transitions in care for patients and families across our regional health care system

Indicator: Percentage of eligible patients from the existing roster and the OHaH successfully transitioned into LP model, and new home care patients accepted into the LP



	Actual	Target
26-Q1	100	100
26-Q2	100	100
26-Q3	100	100
26-Q4	100	100

Describe the tactic(s) we are implementing to achieve this objective:

100% of eligible patients from the existing roster / old model approached to transition to LP

26% of eligible patients from the existing roster / old model provided consent to transition to the LP. This metric is not expected to change unless a change is made in Provincial direction.

100% of new home care patients were accepted into the LP.

All new home care patients eligible to participate were enrolled into the FLA LP.

No provincial update or direction on strategy to re-approach patients who did not provide consent to transition (e.g. implied consent process).

Cumulatively 215 patients have been admitted to the FLA LP from go-live to end of Q4, 57 were admitted in Q1 and 27 admitted in Q2, 49 admitted in Q3, 43 admitted in Q4.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Definition: EVP - Hann
MRP - Hart
REPORTING COMMITTEE - Patient Care & Quality Committee

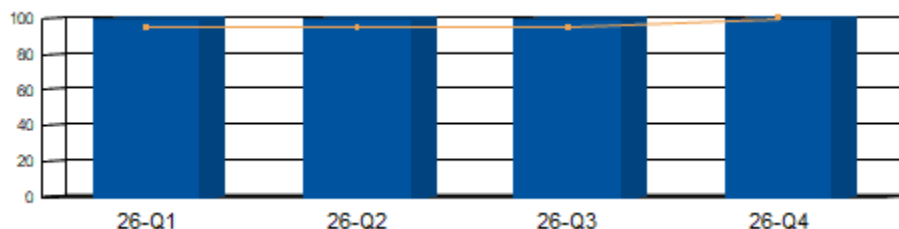
Target: Target 25/26: 100% Perf. Corridor: Red <75% , Yellow 75% - 94% , Green 95% or above

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

b. Ensure smooth transitions in care for patients and families across our regional health care system

Indicator: Urgent home care cases addressed within 24 hours for Loyalist FHT patients



	Actual	Target
26-Q1	100	95
26-Q2	100	95
26-Q3	100	95
26-Q4	100	100

Describe the tactic(s) we are implementing to achieve this objective:

There were no reported urgent home care cases in Q1, Q2. In Q3 there were 20 urgent referrals with 100% of referrals addressed within 24 hours. There were no reported urgent home care cases in Q4.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Definition: EVP - Hann
MRP - Hart
REPORTING COMMITTEE - Patient Care & Quality Committee

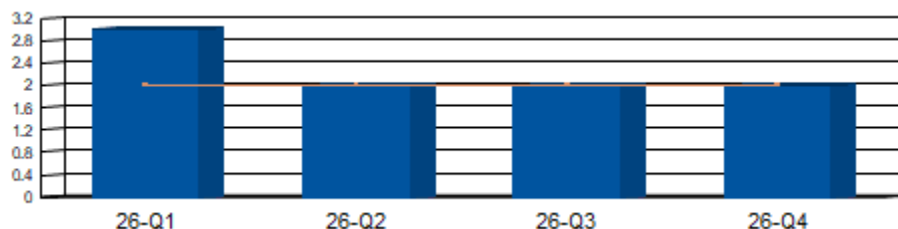
Target: Target 25/26: 95% Perf. Corridor: Red <75% , Yellow 70% - 94% , Green 95% or above

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

b. Ensure smooth transitions in care for patients and families across our regional health care system

Indicator: At least 2 clinics for both CHF and COPD offered monthly in Kingston or Napanee (24 clinics per year)



	Actual	Target
26-Q1	3	2
26-Q2	2	2
26-Q3	2	2
26-Q4	2	2

Describe the tactic(s) we are implementing to achieve this objective:

2 clinics offered monthly in Napanee and Kingston. Improve access for patients with CHF to a specialist after discharge; Physician assistant to follow up for discharged patients.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

COPD Q4 Performance: 25.89 %. CHF Q4 Performance: 27.32 %.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

COPD: The target for this indicator was to improve 5% from baseline(32%) with the target of 27%. The current performance was 25.89% which indicated we met the target. CHF: The target for this indicator was to improve 5% from baseline(35%) with the target of 30%. The current performance was 27.32% which indicated we met the target.

Definition: EVP - Fitzpatrick
MRP - Dave
REPORTING COMMITTEE - Patient Care & Quality Committee

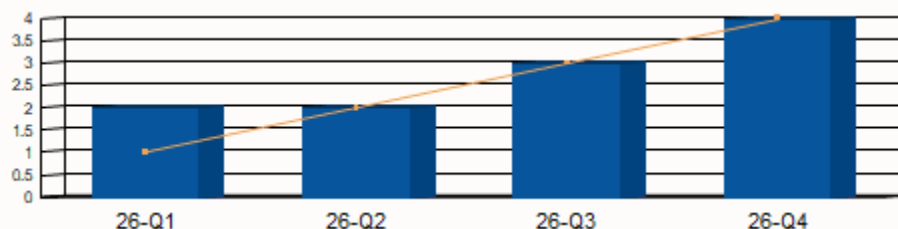
Target: Target 25/26: 75% Perf. Corridor: Red <50% , Yellow 50%-74% , Green 75% - 100%

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

c. Lead the evolution of people-centred care

Indicator: 12 patient stories which highlight the patient experience including, where appropriate, KHSC's response to their unique equity considerations



	Actual	Target
26-Q1	2	1
26-Q2	2	2
26-Q3	3	3
26-Q4	4	4

Describe the tactic(s) we are implementing to achieve this objective:

12 Patient Stories shared which highlight the patient experience, including where appropriate, KHSC's response to their unique equity considerations.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Target of 4 patient stories shared this quarter was met and included:

A patient story was shared at the January Patient Care and Quality Committee (PCQC) meeting that was also shared with the leadership of the Ventilator Equipment Pool. The impact of the work of the Ventilator Equipment Pool team to a patient living with ALS' ability to receive quality care at home was particularly impactful. This particular patient story was identified by Dr. Fitzpatrick with a goal of sharing it with students. The recording process was supported by Matthew Manor, Digital and Creative Communications Advisor.

The March PCQC meeting included a written story as well as a video recorded story highlighting the importance of the role of caregivers in patient care and the importance of patient-centred behaviors to the recovery process. The story was shared with Connell 10 and the Hospital Elder Life program staff.

A story of a patient's experience with their loved one's care related to the emergency department was shared by a council member during a Mental Health and Addictions PFAC meeting. Angela will be connecting her to leadership in the ED to share her experience.

A client who received care at the Detoxification Centred generously reached out to staff to share feedback about his positive experience which was shared within the program and brought to Angela's attention. Angela has connected with the client and recorded his story which focused on patient-centred priorities and behaviors. The client has consented to having the story shared in the future for education and quality improvement purposes. His story also recognized the value of some of the activities he engaged in that were supported by the KHSC PFAC led PFCC project grant initiative.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes, we have met the objective of sharing 12 patient stories by hearing patient stories in different ways across the organization. We continue to identify opportunities to share patient stories and experiences to inform quality improvement and learning.

Definition: EVP - Fitzpatrick
MRP - Morin
REPORTING COMMITTEE - Patient Care & Quality Committee

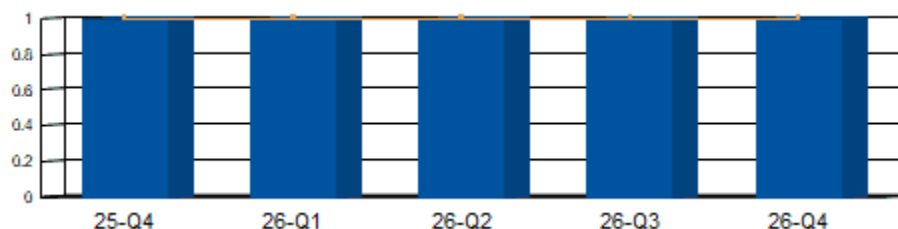
Target: Target 25/26: 100% Perf. Corridor: Red (Q1 = <0, Q2 = 0, Q3 = 1, Q4 = 2) , Yellow (Q1 = 0, Q2 = 1, Q3 = 2, Q4 = 3) , Green (Q1 = 1, Q2 = 2, Q3 = 3, Q4 = 4)

Q4 FY2026 Strategy Performance Indicators Report

1. Ensure quality in every patient experience

d. Create the space for better care

Indicator: Plans for addressing short-term, urgent patient-care facility needs are meeting quarterly milestones Y/N



	Actual	Target
25-Q4	1	1
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

The targeted objectives for the Redevelopment and Facilities portfolio have been successfully achieved, and the program remains on track against all major year-end deliverables.

The Redevelopment Strategic Plan was submitted to the Ministry of Health on schedule and has been well received, with all required supporting documentation accepted. Priority Bridging Projects, including the Fire Alarm System Replacement and Emergency Power Upgrades, have advanced from planning into implementation, with the Fire Alarm project now in active construction and the Emergency Power project progressing through final procurement and shop drawing review.

At the new hospital site on Clogg's Road, master planning is progressing well in close collaboration with the City of Kingston, with zoning approval anticipated shortly and site investigations nearing completion. Concurrently, planning continues with Queen's University, St. Lawrence College, and municipal partners to advance the broader Life Sciences and Health Campus vision.

Optimization initiatives for the Emergency Department, ICU, inpatient units, and other key clinical areas are underway, with consultant procurement initiated and program updates progressing in partnership with clinical teams. In parallel, the 2026–27 HIRF capital program and a five-year infrastructure renewal plan have been advanced to support the ongoing modernization of critical systems across both hospital sites.

Overall, all major portfolio objectives have been met as planned, and the Redevelopment and Facilities program remains firmly positioned to achieve its strategic milestones and maintain strong momentum into the next phase of execution.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

The Redevelopment Strategic Plan was submitted to the Ministry of Health on schedule and has been well received, with all required supporting documentation accepted. Priority Bridging Projects, including the Fire Alarm System Replacement and Emergency Power Upgrades, have advanced from planning into implementation, with the Fire Alarm project now in active construction and the Emergency Power project progressing through final procurement and shop drawing review.

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Overall, all major portfolio objectives have been met as planned, and the Redevelopment and Facilities program remains firmly positioned to achieve its strategic milestones and maintain strong momentum into the next phase of execution.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

The targeted objectives for the Redevelopment and Facilities portfolio have been successfully achieved, and the program remains on track against all major year-end deliverables.

Definition: EVP - Anand
MRP - Anand
REPORTING COMMITTEE - People, Finance & Audit Committee

Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Prior Targets

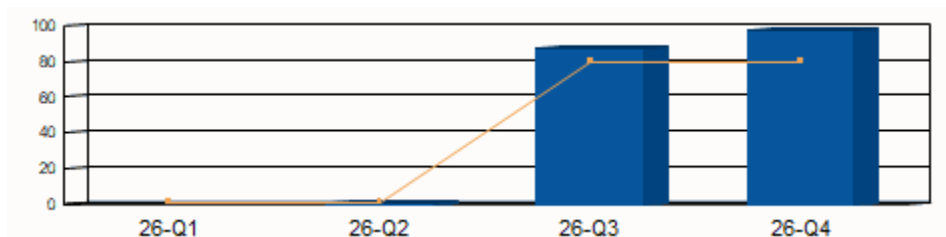
Target 24/25: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

2. Nurture our passion for caring, leading and learning

a. Foster a safe, healthy, innovative working environment that inspires and motivates the people who work, learn and volunteer at KHSC

Indicator: Percentage of team-level Psychological Health and Safety risk assessments completed (inclusive of workplace violence-related risks)



	Actual	Target
26-Q1		1
26-Q2	1	1
26-Q3	87	80
26-Q4	97	80

Describe the tactic(s) we are implementing to achieve this objective:

In alignment with KHSC's Psychological H&S (PHS) framework and action plan, and to respond to GWS employee and physician experience survey results, the focus of Q4 was on supporting teams with outstanding action plans and refinement of submitted plans to ensure all teams had identified meaningful actions to promote the PHS/address team-level psychosocial stressors.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

As of the end of Q4, 97% of teams requiring Team PHS actions plans had submitted one. This is a total of 107 Team action plans submitted.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes, we achieved our target for this fiscal.

Definition: EVP - Naraine
MRP - Noonan
REPORTING COMMITTEE - People, Finance & Audit Committee

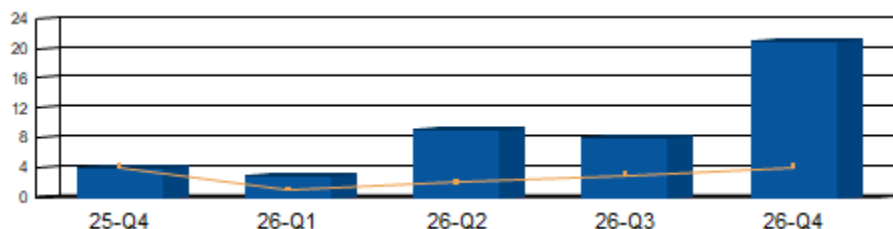
Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

2. Nurture our passion for caring, leading and learning

b. Empower and develop our people

Indicator: Number of cross-training events that take place



	Actual	Target
25-Q4	4	4
26-Q1	3	1
26-Q2	9	2
26-Q3	8	3
26-Q4	21	4

Describe the tactic(s) we are implementing to achieve this objective:

No change from tactics used in prior quarters.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Courses and participant listed below.

15 staff were captured for ACLS certification
16 staff were captured for PALS training
52 staff were captured for BLS
28 staff for the Charge Nurse Workshop
28 Staff for the GPA training
26 Staff for Recognize and Respond workshop
43 staff were captured for Mentor Education Program

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes, on track. Consistently exceeding target

Definition: EVP - Hann
MRP - Mitchell
REPORTING COMMITTEE - Patient Care & Quality Committee

Target: Target 25/26: 100% Perf. Corridor: Red (Q1 = <0, Q2 = 0, Q3 = 1, Q4 = 2) , Yellow (Q1 = 0, Q2 = 1, Q3 = 2, Q4 = 3) , Green (Q1 = 1, Q2 = 2, Q3 = 3, Q4 = 4)

Prior Targets:

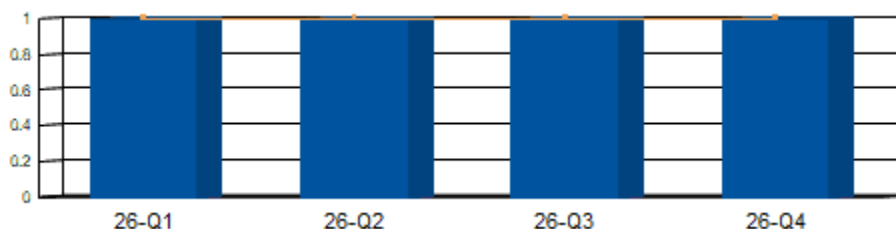
Target 24/25: 100% (4 events) Perf. Corridor: Red Q1: <0, Q2: 0, Q3: 1, Q4: 2, Yellow Q1: 0, Q2: 1, Q3: 2, Q4: 3. Green Q1:1, Q2: 2, Q3: 3, Q4: 4.

Q4 FY2026 Strategy Performance Indicators Report

2. Nurture our passion for caring, leading and learning

c. Develop confident, caring and capable leaders

Indicator: Launch leadership readiness program (Y/N)



	Actual	Target
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

Establishing a resilient and prepared workforce requires providing employees with defined opportunities for professional growth and advancement, with leaders serving a pivotal function in this process. Effectively engaging, supporting, and developing talent enhances our ability to fulfill organizational objectives and strategic priorities, reduce risk to cultivate and support capable leaders for successful execution. Outlined fourth quarter initiatives included:

- Launch 4 OnDemand offerings
- Review potential business case for digital tools
- Implement updates to the PA/PDP documents for the 2026/27 fiscal year
- Publish report on digital transformation and AI as it relates to leaders
- Attend to elements of the operational plan that support psychological health & safety for new and emerging leaders

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

To expand our learning catalogue and support emerging and new leaders, 9 new courses were added in the quarter including a guide to mentor others, workplace integrity and ethics, solving problems and team development. As part of evaluating new programs, we have had 36 staff begin the project and change management certificates with 13 completed to date. This compliments the 20 graduates to date who have completed the 14-week blended learning Elevate and Inspire emerging leader program. 66 leaders undertook the revamped leader onboarding program with 36 who were new to leadership. The SPARK leadership program for managers has had 49 and 32 leader participants respectively. grew and is now incorporated into onboarding and is part of connections with other leaders for peer support and discussions. The review and feedback on the performance development processes continued with updates and a notable significant increase in compliance with their completion 52% in alignment with the OHA average. Systems thinking resources and articles were published in the Leadership Exchange newsletter.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

We reached our target successfully.

Definition: EVP - Naraine
MRP - Mulima
REPORTING COMMITTEE - People, Finance & Audit Committee

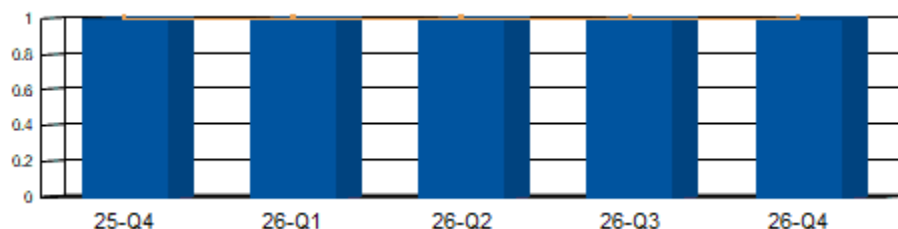
Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

3. Improve the health of our communities through partnership and innovation

a. Be a hospital beyond our walls that delivers complex, acute and speciality care where and when it is needed most

Indicator: KHSC participates in Ministry-directed OHT initiatives Y/N



	Actual	Target
25-Q4	1	1
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

The FLA OHT works closely with several KHSC departments to achieve its objectives, including: Project Management Office, Decision Support, Emergency Department, Clinical Information Services, Technology Services, the Heart Function Clinic, the Pulmonary Function Laboratory, Division of Respiriology, Division of Cardiology, and Ambulatory Care Clinics.

Staff across these departments and clinics remain engaged with the FLA OHT work this year, participating in working groups and contributing to OHT initiatives. The Project Management Office now provides oversight and training for two Project Managers who are fully allocated to OHT projects (Integrated Care Pathways and Primary Care Attachment, funded by the OHT). KHSC continues as the implementation site for CHF and COPD PROM and PREM collection and offers Rapid Access Clinics for urgent/high-risk individuals admitted for COPD/CHF. KHSC is the HIC for the Leading Project in Home Care, and for Integrated Care Pathways Enrolment reporting. KHSC's Heart Function Clinic continues their collaboration with the Frontenac County Community Paramedics to build their Hospital at Home program. KHSC stands ready to support FY25-26 priorities as directed by the Ministry of Health/Ontario Health.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Staff across several programs at KHSC remain engaged with the FLA OHT work this year, participating in working groups and contributing to FLA OHT initiatives. KHSC continues as the implementation site for CHF and COPD PROM collection, offers Rapid Access Clinics for urgent/high-risk individuals admitted for COPD/CHF, and is the HIC for the Leading Project in Home Care. KHSC's Heart Function Clinic continues their collaboration with the Frontenac County Community Paramedics to build out their Hospital at Home program. KHSC stands ready to support priorities as directed by the Ministry of Health/Ontario Health during Fiscal 2027.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes, we have met this objective during Fiscal 2026 and are on track to meet it during Fiscal 2027.

Definition: EVP - Fitzpatrick
MRP - Fitzpatrick
REPORTING COMMITTEE - Governance

Target: Target 25/26: 100% Perf. Corridor: Red No = 0 , Yellow Blank = in progress , Green Yes = 1

Prior Targets:

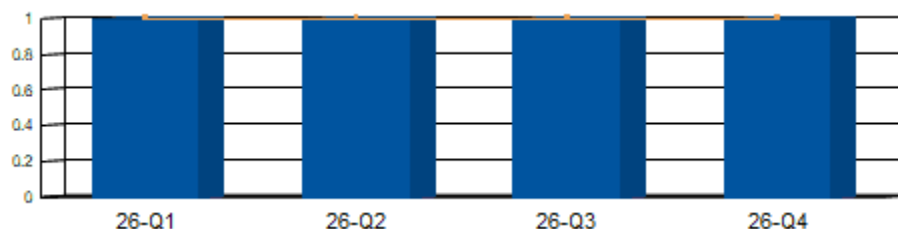
Target 24/25: 100% Perf. Corridor: Red No = 0 , Yellow Blank = in progress , Green Yes = 1
Target 23/24: 100% Perf. Corridor: Red <70% , Yellow >70% and <79% , Green >80%

Q4 FY2026 Strategy Performance Indicators Report

3. Improve the health of our communities through partnership and innovation

a. Be a hospital beyond our walls that delivers complex, acute and speciality care where and when it is needed most

Indicator: Evidence of effective identification, submission, and advocacy for critical break/fix and optimization needs at the regional level, and evidence of execution of agreed-upon plans



	Actual	Target
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

Within the local Lumeo operations governance structure, the use of our established intake and triage process for issue escalation processes and workflows continues ensuring that issues that can be managed locally are investigated and resolved, and break/fixes and patient safety concerns that require the Regional Lumeo Operations team oversight and involvement are escalated in a timely manner.

The CCIO and CMIO continue to represent KHSC at regional clinical advisory committees/councils and weekly check-ins with the Regional Lumeo Operations team advocating KHSC's priorities and needs. This advocacy is further supported by our leadership-level representatives who sit on the many specialty or discipline-specific Lumeo regional working groups.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Through our local Lumeo governance structure, the organization continues to identify, locally prioritize, and escalate critical break/fix and patient safety concerns to the Regional Lumeo Operations team for further investigation and resolution.

The turnaround time by the Regional Lumeo Operations team on high priority issue resolution continues to be slow and impacted by regional resource capacity and competing demands. KHSC continues to voice concerns around prioritization of work, regional team resource capacity, attrition of skilled resources, and the effectiveness of the regional working groups.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we meet the objective by year end?

Yes, KHSC continues to collaborate with the Regional Lumeo Operations team on stabilizing the RHIS, identifying, advocating for, and escalating priority issues through established local and regional processes to support clinical operations.

Definition: EVP - Gamache-O'leary
MRP - Gamache-O'leary
REPORTING COMMITTEE - People, Finance & Audit Committee

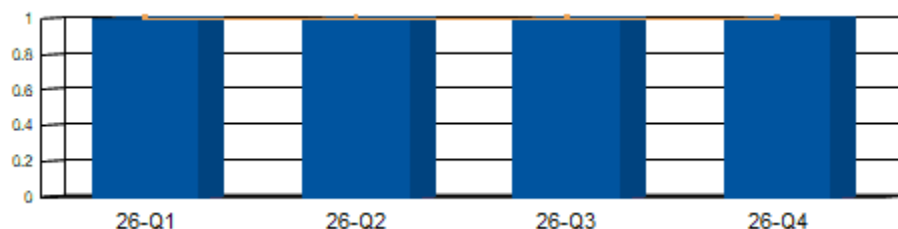
Target: Target 25/26: 100% Perf. Corridor: Red No = 0 , Yellow Blank = in progress , Green Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

3. Improve the health of our communities through partnership and innovation

a. Be a hospital beyond our walls that delivers complex, acute and speciality care where and when it is needed most

Indicator: KHSC informatics team and Lumeo operational governance structure in place



	Actual	Target
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

KHSC's Clinical Informatics (CI) team continues to fill approved positions, working towards a fully staffed team in this first full year of operation. At the end of Q4, there remains one CI Trainer position to fill.

The CI team continues to work across operational units within KHSC and leverages the developed local Lumeo operations governance structure to move KHSC Lumeo priorities forward to the Regional Lumeo Operations team.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

In this fourth quarter, we finalized the CI Trainer Lead job description/role and filled with an internal candidate who has been working within the training team since pre go-live. We continued recruitment efforts for the remaining vacant CI Trainer position. This is the last position to be filled to complete the CI team complement.

The local Lumeo operations governance structure is functioning well and supports decision making, issue escalation and risk management within KHSC and up to the Regional Lumeo Operations team. The Medical Informatics Council and Local Lumeo Director's Council continue to be well attended and have shown good engagement of medical and clinical leadership across the organization.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes. The CI team is almost fully staffed, and the local Lumeo governance structure is functioning well with continued focus on monitoring its effectiveness.

Definition: EVP - Gamache-O'leary
MRP - Gamache-O'leary
REPORTING COMMITTEE - People, Finance & Audit Committee

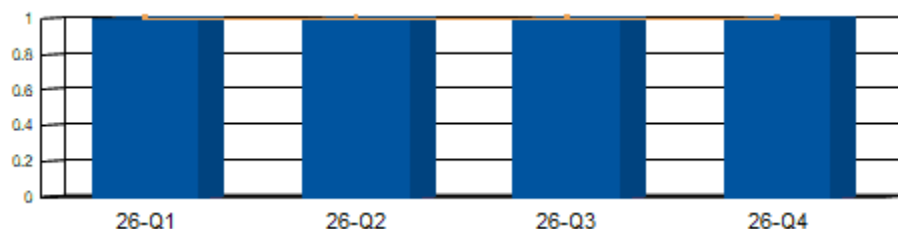
Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

3. Improve the health of our communities through partnership and innovation

b. Discover and apply innovations that improve patient outcomes and make our communities healthy

Indicator: Approved plan for CAR T-cell therapy is in place (Y/N)



	Actual	Target
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

We have planned additional infrastructure and a new CAR T-cell product to facilitate additional patients who can benefit from CAR T-cell therapy.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

WE have completed the planned 12 CAR T-cell cases for Fiscal 2026.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

This objective has been met - 12 CAR T-cell cases completed. We anticipate doing even more during Fiscal 2027.

Definition: EVP - Fitzpatrick
MRP - Fitzpatrick
REPORTING COMMITTEE - Patient Care & Quality Committee

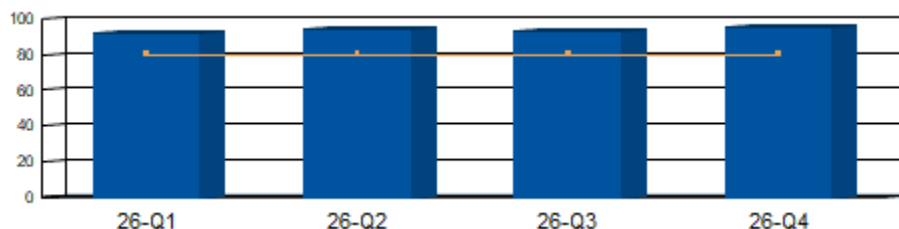
Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

4. Launch KHSC as a leading centre for research and education

a. Foster a culture of teaching, learning, research and scholarship

Indicator: KHSC achieves 80% of total placement requests (Y/N)



	Actual	Target
26-Q1	92.00	80
26-Q2	94.00	80
26-Q3	93.52	80
26-Q4	95.00	80

Describe the tactic(s) we are implementing to achieve this objective:

KHSC views learning and education as an ongoing practice that we embrace and foster among our students, residents, staff, physicians and leaders. It is also our pipeline for recruitment.

With over 2,000 students/learners a year, placed at either the Kingston General Hospital or Hotel Dieu Hospital sites, we strive to be a leader in interprofessional education and work with our educational partners to plan and deliver a high quality learning experience for all members of our learning community. By nurturing this culture for the pursuit of knowledge, KHSC will remain on the leading edge of care and become a place where our people are constantly inspired to learn, discover and want to work.

It is imperative that we create the capacity for as many students placement opportunities at KHSC.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

We aim to accept and accommodate at least 80% of our total requests for student placements. While some students come to us from nearby schools such as Queen's University and St. Lawrence College, we also place students from across the country. KHSC will accept students from Canadian accredited colleges and universities, independent accredited business schools/colleges, and other health care centres and agencies. We have over 70 affiliation agreements and growing.

There are several factors that contribute to us declining placement requests, such as clinical workload/demands on staff, aligning resources with staffing and matching students with the appropriate preceptors. However, KHSC has made new efforts to strategically plan and accommodate to meet our educational mandate and support our educational partnerships.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we meet

Yes. In Q4 KHSC received a total of 395 Requests for student placements. We approved 374 (95%) and declined 21 (5%). We surpassed our 80% target.

Definition: EVP - Gillies
MRP - Gillies
REPORTING COMMITTEE - People, Finance & Audit Committee

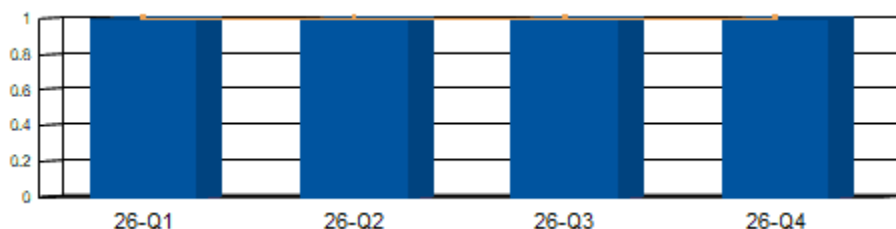
Target: Target 25/26: 80% Perf. Corridor: Red <55% , Yellow 56% - 79% , Green 80% - 100%

Q4 FY2026 Strategy Performance Indicators Report

4. Launch KHSC as a leading centre for research and education

a. Foster a culture of teaching, learning, research and scholarship

Indicator: Implementation project meets quarterly milestones (Y/N)



	Actual	Target
26-Q1	1	1
26-Q2	1	1
26-Q3	1	1
26-Q4	1	1

Describe the tactic(s) we are implementing to achieve this objective:

The strategic plan is drafted and has been circulated for comments and feedback. Branding continues to move forward with work to develop signage and public facing messaging.

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

The team is on track to present the draft strategic plan to the KHSC - RI board in June.

Definition: EVP - Smith
MRP - Smith
REPORTING COMMITTEE - Research

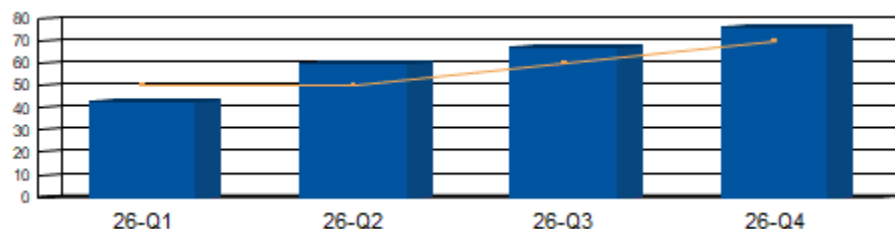
Target: Target 25/26: 100% Perf. Corridor: Red: No = 0, Yellow:Blank = in progress , Green: Yes = 1

Q4 FY2026 Strategy Performance Indicators Report

5. Advance equity, inclusion, and diversity and address racism to achieve better outcomes for patient, families, providers and staff

a. Create an inclusive environment for patients, families and everyone who works, learns and volunteers at KHSC

Indicator: Percentage of current KHSC employees who have completed foundational inclusion training



	Actual	Target
26-Q1	42.75	50
26-Q2	60.00	50
26-Q3	67.00	60
26-Q4	76.00	70

Describe the tactic(s) we are implementing to achieve this objective:

The Integrated Inclusion Framework (IIF) was created to expand our efforts in diversity, equity, and inclusion, placing renewed emphasis on patients, families, and the community. By taking a more unified approach, we can address key gaps affecting both staff and patients. This framework guides inclusion work throughout KHSC, and a year 1 Action Plan was created making it easier to measure progress, focus initiatives, evaluate results, coordinate actions, and foster a welcoming, supportive environment for everyone who visits or works with us. Q4 tactics included:

- Update bilingual signage
- Review and monitor completion rates of Foundations course assignment
- Engage interest holders in data collection discussions
- Look for opportunities to integrate into other corporate priorities i.e. Psychological H&S Framework, Patient stories
- Review progress to determine next actions for upcoming fiscal year
- Implement improvements in data collection and supports
- Assess impact of improvements

Explain the current performance of the objective as of this quarter. Where possible, express statistics and numbers in plain language, focusing on the impact to patients and staff

The IIF Actions included the completion of a mandatory Foundations for Inclusion course for all employees to level-set knowledge and understanding and this was also linked to the Quality Improvement Plan. By the close of Q4, our completion rate was 76%, surpassing the target of 70% and representing over 4,400 individuals. This is now embedded into new hire orientation for ongoing sustainability. Funded bilingual signage improvements occurred at the HDH site and additional training occurred for registration and Emergency department staff was offered to emphasize the importance of French Language Services and Active Offer to patients and families coming for care. In Q4, staff and patient stories were shared at the Board level to demonstrate how inclusion initiatives are affecting day-to-day experiences and to support leadership oversight. Work continued on data collection discussions to improve how we set the foundation to better target and measure equity and inclusion outcomes over time. We welcomed new members to the Inclusion Steering Council to broaden perspectives and strengthen support for this work. A 'what's next' session generated priorities for the coming year, and the themes were consolidated to guide development of next year's inclusion action plan.

Are we on track to meet the objective by year end? If not, explain why and what new tactics are planned to ensure we me

Yes, we met the target.

Definition: EVP - Naraine
MRP - Mulima
REPORTING COMMITTEE - People, Finance & Audit Committee

Target: Target 25/26: (Q1 >= 30%, Q2 >= 40%, Q3 >= 60%, Q4) Perf. Corridor: Red (Q1 <10%, Q2 <20%, Q3 <30%, Q4 <40%) , Yellow (Q1 >=10% to <20%, Q2 >=20% to <30%, Q3 >=30% to <40%, Q4 >=40% to <50%) , Green (Q1 >= 30%, Q2 >=40%, Q3 >=50%, Q4 >=60%)

Q4 FY2026 Strategy Performance Indicators Report

Status:

N/A

Currently Not Available



Green-Meet Acceptable Performance
Target



Red-Performance is outside
acceptable target range and require



Yellow-Monitoring Required,
performance approaching