Excellent Care for All

Quality Improvement Plans (QIP): Progress Report for 2014/15 QIP

The Progress Report is a tool that will help organizations make linkages between change ideas and improvement, and gain insight into how their change ideas might be refined in the future. The new Progress Report is mostly automated, so very little data entry is required, freeing up time for reflection and quality improvement activities.

Health Quality Ontario (HQO) will use the updated Progress Reports to share effective change initiatives, spread successful change ideas, and inform robust curriculum for future educational sessions.

ID	Measure/Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
1	80th percentile - longest wait measured in days Days paediatric 2013/14 Hospital collected data	134.00	151.00	183.00	On an aggregate level our performance has markedly shifted over the past 3 quarters secondary to the reduction in target (from 181 days to 151 days) and significant increase in referrals with the adoption of North York General's autism service. Our ongoing performance review of demand and capacity demonstrates ongoing greater demand for this assessment service with increased referrals by 100% since fiscal year 2012/13. All clinics continue to review service delivery models and potential realignment to ensure further standardization. External review of the clinic and registration services this past fiscal year have provided areas for improvement that will be realized in the 2015/16 fiscal year.

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Change Ideas from Last Years QIP (QIP 2014/15)	Was this change idea implemented as intended? (Y/N button)	Lessons Learned: (Some Questions to Consider) What was your experience with this indicator? What were your key learnings? Did the change ideas make an impact? What advice would you give to others?
1. Redesign of the model of service delivery of North York General's clinic to align and be standardized to the current design (e.g. work load levelling) 2. Centralization of referrals across all sites to standardize process 3. Cross linkage of initiatives - Appointment Services redesign with centralized referral flow 4. Implementation of visual management system of performance to monitor demand, capacity, utilization within Appointment Services 5. Implementation of a new 'referral' process to community practitioners (18 month initiative) to reduce the number of clients waiting for service secondary to 'defects' within the referral form.	Yes	All change ideas were implemented, and while they streamlined activity, the demand for service in the past 12 months exceeded expectations. Since 2012 there has been a 98% increase in referrals for Autism services. Since the acquisition of North York General services for Autism we have experienced more referrals than originally anticipated (two fold increase), coupled with ceiling capacity has resulted in increased wait.

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2	Total Margin (consolidated): % by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year. % N/a Q3 2013/14 OHRS, MOH	1.62	0.50	0.40	All change strategies have been successfully implemented with ongoing monthly variance reports review, business microanalysis, business optimization and quarterly performance reporting conducted.

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1. Monthly/Quarterly Performance Reporting 2. Business Optimization Strategy 3. Implementation of Long Term Deficit Strategy at Senior Management TEam	Yes	Active management enables predictive ability in fiscal planning - quarterly performance reporting, monthly variance reporting and the Multi Criteria Decision Analysis fiscal planning has been successful in ensuring targeted management.

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3	Percentage of families that would rate their partnership at Holland Bloorview as 'authentic' % Family Leaders 2013/14 In-house survey	88.00	90.00	89.30	We continue to value the voice of our clients within all activities of the organization, and seek input on all initiatives. The measure was to ensure that our engagement with families is meaningful and authentic. We achieved performance within the specified performance corridors and were very close to target. We continue to use themes to assist us in our active partnerships with our families to make their experiences, as well as ours, more enriching and fruitful in our shared outcomes.

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1. Partner with Bloorview Research Institute to explore validating the tool for 'engagement' 2. Focus group interviews to identify areas for change in augmenting engagement, respect and authenticity 3. Exploration of more rigourous statistical analysis between Client Relations data and survey responses	No	The change idea not implemented this fiscal year was a full partnership in developing the validated tool. This will be explored next fiscal year.

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4	Percentage of clients contacted post inpatient discharge within 3 business days to assess if clients have been appropriately integrated back into the community % Discharge families 2014/15 Hospital collected data	CB	80.00	83.10	This new measure was developed to address care transitions of clients as they re-enter the community after an inpatient stay. A telephone survey is administered to families 3 business days after discharge to explore if they understood the discharge instructions, as well as an opportunity to ask questions of their care providers. The tool was developed and piloted in 2013/14 and performance was tracked as of Q3 FY 2014/15. This indicator will continue on the 2015/16 QIP as part of our commitment to care transitions.

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1. Development of the Discharge Tool for Families to ensure community integration 2. Development of Discharge Process/Pathway for warm handovers into the community 3. Implementation of a 3 business day phone call to families to ensure re-integration home 4. Implementation of family satisfaction survey of discharge process for future quality improvement initiatives 5. Training of key staff as part of core competencies (nursing)	Yes	All elements of this new care process were implemented, and reportable analysis of the survey and process commenced in Q3 Fiscal Year 2014/15. Helpful for the organizations to consider is the staged approach to implementation, the embedding of clear process into models of care, and thoughtful reflection and inclusion of families in the development, implementation and evaluation of the pilot.

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5	From NRC Canada: "Overall, how would you rate the care and services you received at the hospital (inpatient care)?" (add together % of those who responded "Excellent, Very Good and Good"). % All patients Oct 2012- Sept 2013 NRC Picker	68.00	70.00	68.70	Our goal was to continue to refine the sampling methodology and increase our sample size to reflect improvement. We achieved a similar sample size as that in 2013/14 with a total of 615 surveys fully completed and over 800 partially completed but not included in the analysis. Last fiscal year we had 677 families responding. While we feel this was successful, we continue to explore different methodologies (including email) to ensure all voices of families are included. This year we refined questions that aligned with two separate but connected TC-LHIN initiatives on Quality and Equity.

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1. Redesign of methodology to ensure more voices are captured through the use of email and website feedback 2. Focus group interviews with our Family Leaders and FAC to better understand 'what' makes the care experience 'excellent' 3. Pulse Checks with our inpatient units to ensure all families receive surveys upon discharge	Yes	With all change ideas presented, our response rate did not improve and therefore will be exploring other options to increase response rate.

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6	Percentage of 'straight forward complaints' resolved within 10 business days % All patients Fiscal year 2014/15 Hospital collected data	CB	70.00	100.00	We advanced our measure of the patient complaint process from 'contacting' clients (process measure) to resolution of complaints (outcome measure). While we are in the beginning processes of tracking and measuring outcome resolution of issues/concerns, we continue to review timeliness of resolution on a monthly/quarterly basis across all areas of the organization. Of note while complaints continues to increase significantly, we are meeting and exceeding target.

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1. Develop categorization of complaints with a 'predefined' conceptual framework 2. Partner with families in defining the conceptual framework of 'straight forward', 'moderate' and 'complex' complaints 3. Partner with Programs & Services to provide consultation in complaint resolution	Yes	Critical is having a clear definition of the categories and what defines resolution in each to allow for active monitoring, evaluation and partnership with each operational area for improvement.

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7	Medication reconciliation at admission: The total number of patients with medications reconciled as a proportion of the total number of patients admitted to the hospital. % All patients Most recent quarter available (e.g. Q2 2013/14, Q3 2013/14 etc) Hospital collected data	97.90	100.00	97.10	Performance of medication reconciliation was within the allowable performance corridor (5% tolerance for natural variation in process). The target was the theoretical maximum for medication reconciliation at admission. Our continued strategy is to increase awareness through transparency and reporting. This past year medication reconciliation was tracked at all points of the inpatient stay and we exceeded target. We plan on advancing the target for FY 2015/16 to ensure all points of transition will have processes in place for the elimination of harm through medication error.

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1. Visual management of monthly auditing process 2. Monthly huddles around performance 3. Ongoing medication management discussion at the Medical Advisory Committee 4. Implementation of medication management questions within the 'Tell Us'patient satisfaction survey to link activity to knowledge translation	Yes	We continue to be near the theoretical maximum with sustained performance. While our goal is always towards improvement, pivotal is ensuring sustainability of practice, and cognizant of fluid staffing changes which require focused education to ensure sustained practice. Also key is the visibility, transparent conversation of performance as an opportunity for collective understanding and improvement planning.

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8	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2013, consistent with publicly reportable patient safety data. Rate per 1,000 patient days All patients 2013 Publicly Reported, MOH		0.10	0.00	We continue to maintain our performance in C-difficile with public reporting quarterly and maintaining antibiotic stewardship, hand hygiene and immediate reporting.

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1. Implementation of antimicrobial steward ship 2. Quarterly 'trigger tool' analysis to include potential c-difficile triggers	Yes	All elements were implemented and the lessons learned included the awareness of the very low incidence of C-Difficile within the organization that further improvement would not achieve further result, and considering the cost/benefit/impact of further resource allocation for 'improvement'. Rather focus on sustainability of practice.

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9	Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - consistent with publicly reportable patient safety data. % Health providers in the entire facility 2013 Publicly Reported, MOH	93.00	95.00	97.00	We continue to perform above target for the entire fiscal year. Hand Hygiene performance has been collected across all moments of care and all moments have met or exceeded target. Over the year, the organization conducts well over 3000 audits using an automated electronic platform. Reports are shared, and discussed with service areas.

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1. Performance Reporting within Programs & Services to share results 2. Evaluation of 'electronic auditing tool' to allow for 'real time' information and one on one mentoring at point of audit 3. Targeted Discipline Education - leveraging existing practice councils to shift 'standards of practice' 4. Leverage the Family Advisory Committee and Family Leaders in a new Hand Hygiene Initiative on 'community and family' awareness 5. Just Clean Your Hands Campaign (outpatient campaign) - a joint venture where both clinicians and families wash their hands together to demonstrate technique, and entrench hand hygiene practices within the community 6. Just Clean Your Hands (inpatient campaign) - refreshed education with families every 60 days to understand the importance of hand hygiene and nosocomial spread	Yes	Continued monitoring, and sharing of information regularly (moment of audit, monthly, quarterly) assists in ensuring culture shift and traction.

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10	Percentage of 'eligible staff and volunteers' receiving influenza vaccine annually % Eligible Staff and Volunteers 2014/15 Occupational Health and Safety	60.00	80.00	94.00	This was a new measure implemented this year to link with our theme of reducing hospital acquired infections. As part of a larger TAHSN initiative, the organization implemented several change ideas to improve the vaccination rate of eligible staff (medically able to receive the vaccine) and volunteers. Our rates significantly increased from last fiscal year with a strategic focus on awareness, education, policy implementation and commitment to our most vulnerable populations.

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1. Implementation of staff on an annual basis signing an 'Influenza Vaccination Form' which identifies the reason for not receiving the vaccination 2. Implementation of vaccination as a condition of service or volunteering at Holland Bloorview (if eligible) 3. Improved vaccination with availability across shifts, days and weekends	Yes	Partnered with the other TAHSN organizations, common direction/objective in reducing hospital acquired infections was critical in creating the system impetus for change.

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11	Percentage of staff compliant with 2 client identifiers for all care % All patients 2014/15 Hospital collected data	CB	90.00	91.20	This was a new measure introduced in the 2014/15 QIP as part of the organizations ongoing strategy to embed Accreditation Canada required organizational practices into processes of care and practice. Two client identifiers for all care was introduced with change ideas such as the development and implementation of a branding strategy, manual audits, education and client/family involvement with visual management cues. We exceeded our target and will be advancing this 2015/16 year.

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1. Branding Campaign of 'Ask Me, Match Me' across the organization 2. Ongoing education within risk rounds, business meetings and safety meetings surrounding the campaign and importance 3. Targeted strategy with the Professional Advisory Committee and Collaborative Practice Leads to ensure all staff see the strategy within their own practice	Yes	The organization is committed to embedding leading practices as outlined by Accreditation Canada and CPSI to ensuring safe care. Through ongoing integration of key ROPs and safety in clinical practice and care process the organization is able to advance and sustain safety well after the Accreditation event.

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12	% of inpatients (complex continuing care, rehabilitation and respite clients) with newly acquired pressure ulcers in the last three months (stage 2 or higher) while at Holland Bloorview % all inpatients (excluding sleep study) 2014/15 Hospital collected data	0.74	1.50	1.42	The organization met target for pressure ulcer prevention this past fiscal year. We continue to hover between 0.48% to 1.42% in performance with a strong focus on implementing best practices and using standardized tools for assessment.

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1. Inclusion of 'core competency' during annual re-certification addressing wound prevention and management 2. Auditing of compliance to the 'Braeden Scale' for measuring would risk 3. Review 'high' risk clients and those who go on to develop a pressure ulcer - exploring relationship	Yes	Key to sustainable performance is the embedding of process into practice in formal and informal ways. While the formalized 'core competency' is one strategy to deliver education, the safety walks, one-on-one conversations further embed practice and shift culture.

ID	Measure / Indicator from 2014/2015	Current Performance as stated on QIP14/15	Target as stated on QIP 14/15	Current Performance 2015	Comments
13	Percent of inpatients with a completed Falls Risk Assessment who sustain an accidental fall % all inpatients 2014-15 Hospital collected data	55.00	40.00	3.00	The measure was advanced to ensure that clients identified as high risk through initial assessment were part of the 'falls strategy' plan to minimize risk of sustaining an accidental fall. Arm bands, education and care plans were part of the change ideas to reduce our risk of falls in our most vulnerable clients. We continue to evolve the measure to ensure meaningful and appropriate reduction of avoidable falls.

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1. Implementation of our new 'falls strategy' for high risk clients 2. Levering the Professional Advisory Committee to assess the interdisciplinary role for falls prevention 3. Review of the current paediatric falls assessment tool for specificity and sensitivity	Yes	Partnering with Collaborative Practice allows for the embedding and integration of safety, outcome measurement and evaluation into a clinical practice. Without the linkage to 'practice', the ability to sustain change or shift practice is difficult and often very local and not interdisciplinary.

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14	Percentage of complete medication reconciliation at transfers and discharge % Inpatients 2014/15 Hospital collected data	52.00	80.00	90.60	The organization collected data individually at transfer and at discharge. Medication reconciliation at transfer performance was noted at 92.9% and at discharge 88.2%. The value listed above is an average of both. Performance of medication reconciliation was within the allowable performance corridor (5% tolerance for natural variation in process). The target was the theoretical maximum for medication reconciliation at admission. Our continued strategy is to increase awareness through transparency and reporting. This past year medication reconciliation was tracked at all points of the inpatient stay and we exceeded target. We plan on advancing the target for FY 2015/16 to ensure all points of transition will have processes in place for the elimination of harm through medication error.

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1. Visual management of performance using 'performance boards' on inpatients 2. Quarterly huddling at the performance boards with the Safety Committee 3. Standing agenda item of medication management discussion at the Medical Advisory Committee 4. Standing agenda item on the Nursing Advisory Committee 5. Individual mentoring and follow up with staff through auditing process 6. Implementation of medication management questions on the patient satisfaction survey to explore task and knowledge translation (this will be an 18 month initiative)	Yes	See lessons learned above - similar in nature.

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15	Percent complete Medication Reconciliation on outpatient clinic visits % outpatient clinics 2014/15 Hospital collected data	98.00	100.00	96.30	The organization exceeded target in outpatient medication reconciliation this past fiscal year. All ambulatory clinics are fully reporting and monthly auditing continues to ensure medication reconciliation practices are adhered to in an ambulatory care setting.

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Please see change ideas listed under medication reconciliation within the inpatient setting. The initiatives are similar and span across the continuum of care from inpatients to outpatients.	Yes	Key lessons continue to be the teaching which occurs during the audit process, and the opportunity which is created for dialogue.