Quality Improvement Plans (QIP) 2012/13: Progress on QIP Year Two (2012/13)

Template for Reporting

The following template has been provided to assist with completion of the Progress Report on Year 2 QIP. Please review the information provided in the first row of the template which outlines the requirements for each reporting parameter.

Example

	Priority Indicator (year 2)	Performance as stated in the year 1 QIP	Performance Goal as stated in the year 2 QIP	Progress to date	Comments
Guidance for completing the Performance Report	State the name and definition of the priority level 1 indicator listed in the hospital's year 1 QIP. Reporting on progress of other priority indicators (i.e. levels 2 and 3) is optional.	State the performance associated with the priority indicator that was included in the hospital's year 1 QIP.	State the performance goal that was included in your hospital's year 1 QIP. The stated performance goal indicates the outcomes that the organization expected it would be able to achieve for each priority indicator by the end of the 2011/12 fiscal year, i.e. March 31, 2012.	For each of the indicators listed, state the organization's current data associated with the priority indicator. Reporting periods should align with the periods used to develop the year 1 QIPs. Refer to Appendix 1a of the guidance document for recommended reporting periods for core indicators.	Hospitals should use this section to explain how the performance goals stated in their year 1 QIPs could be improved, describe the challenges faced with meeting their targets, and generally comment on the organization's commitment to meeting the performance targets outlined in their 2012/13 (year 2 QIP).
Priority '1' Indicators					
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. FY - 2009/10, consistent with publicly reportable patient safety data. (Hand hygiene or hand washing is one of the best ways health care providers can prevent the spread of many infections)		90% (FY 2009-10)	90% compliance across the 4 moments of care	1st moment - 90.0% 2nd moment – 99.3% 3rd moment – 94.3% 4th moment – 88.3% (January – December 2012)	Performance currently is meeting the target for 2012/13 for the 1st three moments of care and within the performance corridor for the 4th moment. The organization augmented the hand hygiene campaign with monthly regular audits, and feedback provided to staff to ensure ongoing shift in hand hygiene practices. The improvement has been substantive since 2009/10 and the organization is committed to further improving and sustaining performance throughout 2013/14.
Wait times : 80th percentile in length of wait times for patients. Measured in days. (The number of days 8 out of 10 patients with a query ASD wait to be seen by a physician or diagnostic team.) This does not include psychopharmacology and satellite clinics.		287 days FY 2009-10	≤182 days to first visit in physician and team based diagnostic clinics	Q1 FY 2012/13 - 171 days Q2 FY 2012/13 – 97 days Q3 FY 2012/13 – 89 days for the 80th longest wait	The organization exceeded the performance for January – December 2012 target set out for the 2012/13 QIP. We will continue to focus on our access challenges particularly around autistic assessment services in all sites. The prevalence of

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			(January – December 2012)	autism in the literature is 1 in 165 children in Canada (1 in 150 in the United States) which represents over 190,000 Canadians, with prevalence increasing worldwide (Fombonne et al 2006). Over the past 4 years the organization has seen a continued rise in the number of referrals for assessment of Autism Spectrum Disorders and Neuromotor conditions. We continue to embark upon improvement initiatives to positively impact access.
Wait times: 80th percentile in length of wait times for patients Measured in days. (The number of days 8 out of 10 patients wait to be seen by the Neuromotor program.)	265 days FY 2009-10	≤137 days to first visit in paediatric rehab clinic	Q1 FY 2012/13 - 101 days Q2 FY 2012/13 – 93 days Q3 FY 2012/13 – 50 days for the 80th longest wait (January – December 2012)	The organization exceeded the 2012/13 QIP target for the MOHLTC reporting period. Access continues to be a strategic focus for the organization with ongoing improvement initiatives to ensure timely services for families.
Wait times: 90th percentile in length of wait times for patients Measured in days. (The number of days 9 out of 10 patients wait to be seen in Augmentative Communication.)	406 days FY 2009-10	≤122 days	Q1 FY 2012/13 - 112 days Q2 FY 2012/13 – 89 days Q3 FY 2012/13 – 51 days for the 80th longest wait (January – December 2012)	The organization met the 2012/13 QIP target for the MOHLTC reporting period and has sustained performance over the past 12 months.
Total Margin (consolidated): Percent 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. Q3 2010/11, OHRS	'-1.55%' (FY 2009-10) 3.26% (YTD Q3 FY 2010 -11)	0.5% with a range of 0 - 1%	0.9% (Q3 Fiscal 2012)	The organization met the QIP target for fiscal 2012/13.
Percentage of leaders who would rate the experience as an authentic partnership. Using a new survey administered to our 'family leaders' we will be evaluating the 'authenticity' of the partnerships.	New Practice	80%	88.26% (January – December 2012)	The organization developed a new tool to assess ‘authenticity of partnership’ of all Family Leaders to assess if they felt their relationship was meaningful, respected and partnership. The organization met target and will continue to focus on client and family centred care through active partnership with families.
Percentage of complaints with initial contact/interview commencing the resolution process to families within two business days	New Practice	80%	100% (January – December 2012)	The organization formalized the patient relation process in Q1 of 2012/13 and committed to commencing and informing the resolution process within two business days. The organization exceeded target across the first three quarters by commencing the process 100% of the time. This will continue to be a focus for the organization in 2013/14

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Priority '2' Indicators				
Rate of UTI per 1,000 hospital days: Total number of Urinary Tract Infections (UTIs) in inpatients divided by the number of hospital days multiplied by 1,000. (UTI is a bacterial infection that affects any part of the urinary tract and is acquired in hospital settings)	0.42 per 1,000 patient days (Jan 1, 2010-Dec 30, 2010)	≤ 0.34 per 1000 patient days	0.35 per 1000 patient days (January – December 2012)	The organization met the QIP target for 2012/13. As the numbers of UTI's are relatively low (e.g. 1 per month), and our performance corridors quite tight, one additional infection will impact the rate. The organization continues to focus on UTI's and minimize the incidence through ongoing education and best practices implementation.
Percent complete Med Rec on inpatient admission or outpatient clinic visit. (Medication reconciliation helps reduce medication errors at transition points of care. It ensures the best possible medication history is obtained in order to minimize discrepancies between medications ordered and medications taken.)	New practice in inpatient care no data available	90% compliance	99.3%% compliance (January – December 2012)	The organization exceeded the QIP target in 2012/13 on inpatients which was a concerted effort on nursing practice, and ongoing audits and one-on-one mentoring. The next stage for the organization is to sustain the performance and advance the target.
	New practice in ambulatory care no data available	90% compliance	95.9 % compliance (January – December 2012)	The organization exceeded the QIP target for 2012/13. Ambulatory care medication reconciliation (Med Rec) is a relatively new practice within hospital settings. The organization is committed to further improving performance and expanding the Med Rec across all outpatient clinics.
Priority '3' Indicators				
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. 2010, consistent with publicly reportable patient safety data.(Commonly called C. difficile, is a bacterium that causes diarrhea and other serious intestinal conditions. It is the most common cause of infectious diarrhea in hospitalized patients in the industrialized world.)	0.095 per 1,000 patient days (Jan 1, 2010 -Dec 30, 2010)	Less than 0.1 per 1000 patient days	Q1 FY 2012/13 – 0.0 Q2 FY 2012/13 – 0.19 Q3 FY 2012/13 – 0.18 (January – December 2012)	The organization met the QIP target for fiscal 2012/13 and will continue to implement best practices and incorporate antibiotic stewardship as it relates to CDI.
Pressure Ulcers: Percent of inpatients (complex continuing care, rehabilitation and respite clients) with newly acquired pressure ulcer in the last three months (stage 2 or higher) while at Holland Bloorview - FY 2009/10. (A pressure ulcer is an area of skin that breaks down when constant pressure is placed against the skin. Pressures may result if you are confined to bed or chair for a period of time)	1.36% (FY 2009-10)	less than 2.5%	Q1 FY 2012/13 – 0.7% Q2 FY 2012/13 – 0.0% Q3 FY 2012/13 – 0.75% (January – December 2012)	The organization exceeded the QIP target for fiscal 2012/13. The improved performance has been a concerted effort on implementing best practices for wound care management.
Percent of inpatients with a completed Falls Risk Assessment on admission. (Using a Falls Risk Assessment on admission helps identify those clients at risk for falls so that health care providers can implement all possible measures to eliminate falls for patients within our hospital)	60% (Q3 FY 2010 - 11)	90% compliance	98.1% compliance (January – December 2012)	The organization exceeded the QIP target in 2012/13 secondary to targeted education and monthly audits to ensure compliance.
Wait times: 90th percentile in length of wait times for patients measured in days. (The number of days 9 out of 10 patients wait from date ready for admission to admission for	14 day FY 2009-10	Less than 3 days	0 days (January – December	The organization exceeded the QIP target for fiscal 2012/13 with performance over the past 20 months. While the performance has been

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rehabilitation.)			2012)	exceptional, this can be partially explained by specific reductions in occupancy rate and referrals for specialized services.
Tell Us What You Think survey. Percent "yes" responses to Question: Would you recommend Holland Bloorview Kids Rehabilitation Hospital to family and friends? Rating Scale: Yes/No. (Holland Bloorview's Tell Us What You Think survey also includes a standardized questionnaire called the Measure of Processes of Care (MPOC-20) developed by the CanChild Centre for Childhood Disability Reserach (2004))	98% (January 1, 2010 - Dec 30, 2010)	≥95%	97.6% (January – December 2012)	The organization exceeded the QIP target for fiscal 2012/13 with performance well over 95%. Client centredness continues to be a strategic focus for the organization and we will be embarking on improving our patient satisfaction surveys to include more 'voices' of our clients.
Tell Us What You Think survey. Percent 'excellent and good' rating by clients and /or families. Question: Overall, how would you rate Holland Bloorview? Rating scale: Excellent, Good, Fair, Poor	95% (January 1, 2010 - Dec 30, 2010)	≥95%	93.8% (January – December 2012)	The organization was within the performance corridor of the target for fiscal 2012/13 with performance approaching 94%. Client centredness continues to be a strategic focus for the organization and we will be embarking on improving our patient satisfaction surveys to include more 'voices' of our clients.