Quality Improvement Plans (QIP): Progress Report for 2013/14 QIP

The following template has been provided to assist with completion of reporting on the progress of your organization's QIP. Please review the information provided in the first row of the template which outlines the requirements for each reporting parameter.

Priority Indicator	Performance (2012/13)	**Performance Goal**	Progress to date (2013/14)	Comments
80th perecentile in length of wait for clients receiving their assessment for Autism across all clinics measured in days.	221.00	**182.10**	134.00	On an aggregate level our performance over the past 3 quarters has remained stable with Q1 achieving 133 days, Q2 achieving 131 days and Q3 achieving 139 days. Process control charts demonstrate normal variation. We continue to have greater demand for this assessment service with increased referrals. Our satellite model redesign was completed in 2013 and centralized referral processes were implemented from our satellite clinics. Standardization reduced the number of workarounds and this upcoming fiscal year with the adoption of a new clinic this will ensure 'single point access' for our clients and reduced variability in process. Performance reporting for all of programs & services has been successfully implemented with demand/capacity being noted which as assisted in understanding referral process, standardization of flow and impact. Review of each individual clinic (main site and satellites) each site was well below the 182 day target ranging from 123 days (YTD) to 149 days. All clinics have been undergoing service delivery model realignment to ensure further standardization. Currently underway is the 'external referral' management process that will be completed next fiscal year. Also completed was the Coordinated System for Referral to further ensure all referrals and processes were held in a central repository for analysis and planning.
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.	0.90	**0.50**	1.62	All change strategies have been successfully implemented with ongoing monthly variance reports review, business microanalysis, business optimization and quarterly performance reporting conducted.
From NRC Picker: "Would you recommend this hospital (inpatient care) to your friends and family?" (add together % of those who responded "Definitely Yes" or "Yes, definitely").	97.50	**95.00**	98.00	Our goal this fiscal year was to review the methodology and increase our sample size to reflect improvement. We achieved a 20% increase in our sample size with a total response rate of 649 surveys fully completed and over 800 partially completed but not included in the analysis. Last fiscal year we had 379 families responding (all surveys included) with our total number doubling this year. The organizations focus this year was on 'branding', 'communication' and the 'client voice' to ensure our families knew we were soliciting feedback, what we historically have done with their feedback and high contact communication during our mail out phase to ensure maximal awareness. While we had internally targeted a 20% response rate, that we increased family responses from last year was part of our evaluation process. Implementation of our internal 'pulse checks' were also implemented, however part of our learning was to 'code' the pulse check surveys to better capture if 50% of our families responded. While we feel this was successfully, we were unable to track the total percentage of families responding. Our survey this year also included questions that aligned with two separate but connected TC-LHIN initiatives on Quality and Equity. The questions would assist the organization in furthering medication management practice and our equity platform.

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From NRC Picker: "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").	93.80	**95.00**	96.00	Please see the comments on the 'would you recommend' indicator as the strategies were the same.
Percentage of complaints with initial contact & interview commencing the resolution process to families within two business days percentage	100.00	**95.00**	100.00	We continue to connect with our clients within two business days after receipt of complaint. Of note is this performance has been maintained in spite of our complaint process almost tripling volumes over the 12 month period. That our families feel there is a process to convey concerns as well as compliments is what the organization strives for.
Percentage of Family Leaders who would rate their experience as an authentic partnership.	88.26	**90.00**	88.00	We continue to value the voice of our clients within all activities of the organization, and seeking input on all initiatives. The measure was to ensure that our engagement from the families perspective is meaningful and authentic from their relational role. We achieved performance within the specified performance corridors and were very close to target. Our performance corridor in determining success had a 5% tolerance level to address and account for any variability seen in the process. We have used the 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. We continue to develop a tool in partnership with our research partners.
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.	99.30	**100.00**	98.00	Performance of medication reconciliation was within the allowable performance corridor (5% tolerance for natural variation in process). The target was the theoretical maximum, with the goal in ensuring compliance. Our performance for Q1- 100%, Q2 - 98.7% and Q3 95.7%. We continue to ensure that medication reconciliation is discussed at the Safety Committee, Pharmacy & Therapeutics, Medical Advisory Committee, Quality Steering Commitee and the Quality Committee of the Board. We have implemented all change ideas outlined, with medication results discussed quarterly with teams. We have also implemented Quality Performance Boards for staff to see medication reconciliation performance and the measure is included in the quarterly performance reporting for staff.
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	0.12	**0.10**	0.13	We continue to maintain our performance in C-difficile with public reporting quarterly and maintaining antibiotic stewardship, hand hygiene and immediate reporting. As we have so few cases per year - the goal is to continue in our performance.
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.	90.00	**95.00**	95.00	On an aggregate level the organization met target across all 4 moments for hand hygiene. When analyzing individual moments, the organization either met or was within the 5% tolerance corridor of performance. Results were as follows: Moment 1: Q1-93%, Q2-94%, Q3-93% Moment 2: Q1-97%, Q2-100%, Q3-100% Moment 3: Q1-94%, Q2-96%, Q3-96% Moment 4: Q1-93%, Q2-95%, Q3-92% Change ideas were implemented to assist in improving our performance in hand hygiene, with improving awareness of performance to staff, implementing an electronic platform for auditing and tying exectuive compensation to performance. This upcoming year a broader focus on community prevention and family involvement will be focused upoon.

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Percent of complex continuing care (CCC) residents with a new pressure ulcer in the last three months (stage 2 or higher).	0.48	**1.50**	0.74	The organization met target for pressure ulcer prevention this past fiscal year. We continue to hover between 0.65% to 0.87% in performance with a strong focus on implementing best practices and using standardized tools for assessment.
Percent complete Medication Reconciliation on outpatient clinic visit assessments percentage	95.90	**95.00**	98.00	The organization exceeded target in outpatient medication reconciliation this past fiscal year with quarter performance ranging from 96.4% to 99.1%. The last two ambulatory clinics were made 'live' and ongoing monthly auditing occurs with 50 to 75 charts per month as the sample size. Similar to inpatient medication reconciliation, the same committees are levered to share informationn.
Percent of in-patients with a completed Falls Risk Assessment on admission	98.60	**100.00**	97.30	On an aggregate basis, the organization was within the performance corridor identified (5% variability tolerance)with quarter performance ranging from 96.5% to 98.0% completed assessments. The organization during the Accreditation Journey, and the organizations Integrated Quality Management Plan focused on rebranding and reviewing falls data more closely to assist in preventing falls for our paediatric population. We continue to evolve the measure to ensure meaningful and appropriate reduction of avoidable falls.