Quality Improvement Plans (QIP): Progress Report for 2012/13 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 (2012/13 QIP)	Performance as stated in the 2012/13 QIP	Performance Goal as stated in the 2012/13 QIP	Progress to date *(for specified reporting periods)*	Comments
Guidance for completing the Progress Report	State the name and definition of the **priority level 1** indicator listed in the 2012/13. 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 2012/13 QIP.	State the performance goal that was included in the 2012/13 QIP. The stated performance goal indicates the outcomes that the organization expected it would be able to achieve for each priority level 1 indicator by the end of the current (e.g., 2012/13) fiscal year.	For each of the indicators listed, state the organization's current level of performance associated with the priority indicator. Refer to the reporting periods included below for guidance on completing this section.	Describe how the QIP was implemented for the priority level 1 indicator. Please consider the following topics when completing this section: - What did you learn about the root causes of the current performance? - Were the proposed change ideas implemented? Why or why not? - If implemented, have the changes helped you to achieve or surpass the target? - What will you do to further improve on this indicator?

Priority Indicator (2012/13 QIP)	Performance as stated in the 2012/13 QIP	Performance Goal as stated in the 2012/13 QIP	Progress to date *(for specified reporting periods)*	Comments
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. 2011, consistent with publicly reportable patient safety data	0.46 (Jan-Dec 2011)	0.20 (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	0.41 (Jan-Dec 2012)	• Continue to provide monthly data to the Antibiotic Stewardship Committee and the Medical Quality and Utilization Committee regarding antibiotic usage for specified group of antibiotics— achieved 100% as agenda item at all meetings. • Encountered some delay with information technology systems to enable reporting on time between symptom onset and initiation of precautions. • Continue to focus on improving hand hygiene compliance (see below).
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 - Jan-Dec. 2011, consistent with publicly reportable patient safety data	82.76% (Jan-Dec 2011)	90% (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	85.85% (Jan-Dec 2012)	• Achieving target of providing standardized quarterly reports to 100% of inpatient departments by provider type (physician, nursing, and support services). • Continue to work to improve specific departmental audit numbers for each provider type category. • Completed identification and public posting of hand hygiene champion posters. • Continue as a priority 1 focus in 2013/14 QIP.
Falls: Number of Category 3 falls by inpatients across entire organization. Category 3 - Event/error results in permanent harm/damage. Additional monitoring, prolonged stay and extensive follow-up required. - Total reported events for Jan-Dec 2011	12 (Jan-Dec 2011)	<=6 (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	8 (Jan-Dec 2012)	• Monthly falls occurrences reports sent reliably 100% of the time to inpatient units. • Safety crosses posted & updated on inpatient units. • Falls prevention strategy in place that identifies patients at risk for falls and includes specific strategies to reduce the risk of falls. • Each fall occurrence is reviewed to identify contributing factors and improvements strategies. • Implementing RNAO best practice guideline for falls prevention in 2013.

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Medication Reconciliation: % of medication reconciliations completed within 24hr of admission - Q3 FY 2011/12	75.13% (Q3 2011/12)	90% (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	84.44% (Q3 2012/13)	• Added Med Rec technician to complete reconciliations for admissions through the Emergency Department—will add weekend shifts to improve completion rate. • Continue to audit incomplete medication reconciliations to identify areas for improvement. • Continue to offer ongoing training and education for nurses. • Continue as a priority 1 focus in 2013/14 QIP.
ED Wait times: 90th Percentile ED length of stay for Admitted patients. Q3 2011/12, NACRS, CIHI (ED Process Improvement Program (PIP) Site)	22.9 hr (Q3 2011/12)	19.0 hr (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	23.6h (Q4 2011/12 - Q3 2012/13)	• Achieved 20.0 hr in Q3 2012/13 (Ontario high-volume ED average= 31.9hr). • Working collaboratively with community partners to introduce new discharge options to reduce the Alternate Level of Care (ALC) census and improve access to hospital beds for admitted patients. • Continue as a priority 1 focus in 2013/14 QIP.
Wait Times for Cancer Surgery: % of surgeries completed within priority access targets for breast, bowel, and prostate cancer surgery. Q3 FY 2011/12	85% (Q3 2011/12)	90% (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	98% (Q3 2012/13)	• Target has been achieved through a combination of strategies: implementing a nurse practitioner navigator, diligently reviewing charts for patients with wait times outside of targets, and feedback and reporting to physician and operations teams.

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Respect for Patient Preferences Dimension Score (From NRC Picker: roll-up score of "Treated you with respect/dignity", "Enough say about treatment", Drs & Nurses did not talk in front of you as if you weren't there"	79.8 (Q2 2011/12)	83 (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	80.9 (Q3 2011/12 - Q2 2012/13)	• Achieved 79.9 in Q2 2012/13 • Implemented a Patient Advocate role to establish Patient- & Family-Centred Care Steering Committee. • 10 Patient Experience Partners (PEPs) began meeting in December 2012 with the Patient Advocate and have also begun working with other hospital teams. • Releasing Time to Care™ (RTC) team implemented communication and teaching strategies to improve discharge preparedness. • Work underway to implement RNAO Client Centred Care best practice guideline. • Continue as a priority 1 focus in 2013/14 QIP.
Readmission to Bluewater Health within 30 days for Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) : % of patients with specified COPD or CHF CMGs readmitted to Bluewater Health within 30 days of discharge. Jan-Dec 2011, DAD, CIHI	20.3% (Jan-Dec 2011)	13% (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	19.3% (Q2 2011/12 – Q1 2012/13	• Achieved 19.0% in Jan-Dec 2012 • Continue to work with community partners to optimize discharge follow-up arrangements. • Implementing a comprehensive chronic disease management strategy that includes order sets and care paths. • Continue as a priority 1 focus in 2013/14 QIP.
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. Q3 2011/12, OHRS	0.51% (Q3 2011/12)	> -0.5% (Q1 - Q4 2012/13— Apr 2012 to Mar 2013)	-0.63% (Q3 2012/13)	• Budgets were set and informed by efficiency measures and projected activity. • Information technology (BudMan) is used to provide timely financial performance reports. • Monthly variance analyses and recovery planning continues. • Awaiting final reconciliation of Post Construction Operating Plan (PCOP) funding which is critical to achieving a balanced budget.

Recommended reporting periods and methodologies for core recommended indicators used to populate "Progress to date"

Indicator	Reporting period
Safety	
CDI rate per 1,000 patient days: consistent with publicly reportable patient safety data	Jan-Dec. 2012
VAP rate per 1,000 ventilator days: consistent with publicly reportable patient safety data	Jan-Dec. 2012
Hand hygiene compliance before patient contact: consistent with publicly reportable patient safety data	Jan-Dec. 2012
Rate of central line blood stream infections per 1,000 central line days: consistent with publicly reportable patient safety data	Jan-Dec. 2012
Pressure Ulcers: CCRS	Q2 2012/13
Falls: CCRS	Q2 2012/13
Surgical Safety Checklist: consistent with publicly reportable patient safety data	Jan-Dec 2012
Physical restraints: CIHI OHMRS	Q4 FY 2010/11 - Q3 FY 2011/12
Effectiveness	
HSMR: CIHI. Refer to the CIHI HSMR eReporting tool.	FY 2011/12 as of Dec. 2012
Total Margin (consolidated): OHRS. Refer to the MOHLTC Health Data Branch web portal.	Q3 2012/13
Access	
ER Wait times (Admitted): NACRS, CIHI	Q4 2011/12 – Q3 2012/13
Patient-centred	
NRC Picker / HCAPHS: "Would you recommend this hospital to your friends and family?"	Oct 2011 – Sept 2012
NRC Picker: "Overall, how would you rate the care and services you received at the hospital?"	
In-house survey (if available): "Willingness of patients to recommend the hospital to friends or family"	
Integrated	
Percentage ALC days: DAD, CIHI. Refer to the MOHLTC Health Data Branch web portal.	Q3 2011/12 – Q2 2012/13
Readmission within 30 days for selected CMGs to any facility: DAD, CIHI. Refer to the MOHLTC Health Data Branch web portal.	Q2 2011/12 – Q1 2012/13