Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2016-03-03

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

2016 marks the beginning of a new strategic planning cycle for the Cornwall Community Hospital, with the mission of collaborating to provide exceptional patient centered care. The plan's vision of "Exceptional Care, Always" includes a strong focus on ensuring the organization's sustainability in light of ongoing fiscal challenges in acute care. We must find new ways to continue to improve the patient experience without increased funding. The plan also includes an enhanced focus on patient & family engagement to empower them in their own care, as well as education/communication goals to grow our organizational capacity for continuous improvement through standardization, and the use of technology.

Our goal of Partnering for Patient Safety and Quality Outcomes requires the transformation of healthcare not only within the physical boundaries of the hospital, but across the broader healthcare system. We recognize that we are one part of a larger system that plans, delivers and monitors the healthcare of communities we serve, and that optimum outcomes for patients are achieved through building partnerships with those involved in primary and community care

QI Achievements from the Past Year

Our greatest Quality Improvement (QI) achievement from the past year was the transformation of our Critical Care Unit (CCU) from an "open model" to a closed, intensivist led CCU. This was the end result of our participation in REACHout, a study led by the Royal College of Physicians and Surgeons that is focused on improving the care of critically-ill patients in community hospitals through the implementation of evidence-based clinical decision-making tools, enhanced education, and opportunities to practice advanced care.

The results of the study were used to target improvements at the individual, team and organizational level. The interventions included:

- Education and skills workshops
- Tools (transfer tool and chart audit tool)
- Formal CCU rounding
- Trigger criteria developed to facilitate the recognition of unstable high-risk patients
- Improvement to response time to crises through medical directives
- Improvement to physician response time with full-time intensivists

The support at all levels of the organization was instrumental in the success of the transformation. The organizational changes required to implement the closed model would not have happened without the realignment of priorities and resources.

The result of the intervention is that we now have staff and physicians with the skill set, expertise and processes to effectively care for more complicated patients here at CCH. Multi-disciplinary CCU rounds brought together all health care disciplines in a formalized manner which fosters improved communication, teamwork and collaboration. Patients in the Emergency Department (ED) and across the hospital also benefit from the closed CCU due to access to resources. Our intensivists respond to Early Response Team codes (Code ERT)and support our ED physicians.

The challenge with this improvement was the additional strain on other hospital resources. Due to the advanced care provided and an increase in procedures performed, there is a higher demand on Nursing, Diagnostic Imaging, Respiratory Therapists, Pharmacists, Physiotherapists and other services.

Overall, the initiative is a win for the hospital and the communities we serve. Providing advanced care close to home reduces the impact on patients and family due to the reduced need to travel. Providing advanced patient care has resulted in our staff increasing their skills and expertise, allowing them to work within the full scope of their respective professions.

Integration & Continuity of Care

CCH believes that relationships with primary and community care partners are key to achieving optimal health care for our communities. This is reflected in the new CCH strategic plan direction to " Implement a model of collaborative care focusing on transitions in care and safe discharge ".

With the continuation of the Health Systems Funding Reform (HSFR) all members of the health care system are becoming more reliant on each other's services. In order to maintain the provision of safe, high-quality care within the current financial pressures, we continue to review the services we provide and rely more on our partners for patient care at home or in other health care settings. We are most dependent on the Community Care Access Centre (CCAC) to provide services to assist in timely, efficient discharge; primary care to support the diversion of patients from the emergency rooms and support the transition of patients out of the hospital; and other hospitals and community agencies to provide specialized care.

In 2016/2017 we will continue to be an active and engaged leader of our Health Links. The goals of this initiative support CCH's strategic direction to be responsive to the health needs of our community and to support a model of collaborative care focusing on transitions in care and safe discharge. The Health Links Model of Care centers around the creation and implementation of the Provincial Coordinated Care Plan. Frequent collaboration and communication among the patient, caregiver, primary care provider, Health Link care coordinator and all other service providers will contribute to a decrease in hospital readmissions and in alternate level of care days, while enhancing the patient experience with the health care system. The target population for our Health Links is the frail elderly, palliative or mental health/addictions patient with 2 or more complex medical conditions.

To improve integration within our organization, CCH has also invested in the implementation of an Electronic Health Record to support improved patient safety and quality of care, reducing the potential for medication errors and improving order accuracy, access to test results, and patient safety monitoring.

CCH has chosen to make the priority indicators below the focus of its 2016/2017 Quality Improvement Plan (QIP). CCH maintains a robust performance monitoring system that includes a quarterly Corporate Scorecard and 6 specific indicators called our "Strategies In Action" that are reviewed monthly. Most quality improvement targets established in previous versions of QIPs continue to be monitored through the corporate scorecard, which is available on the CCH website.

Specifically, by March 31, 2017, CCH will:

- Address volumes of Alternate Level of Care (ALC) patients through the standardization of processes around admission to hospital and set expectations around discharge. We will support this work with Interagency Weekly Joint Discharge Review (JDR) meetings and shared accountability among all providers.
- Perform weekly reviews of patient readmissions to the hospital and work with community partners involved in Health Links, aimed at the management of patients with complex conditions within the community. We will work with the CCAC and the Seaway Valley Community Health Centre for referrals and specifically focus on the Chronic Obstructive Pulmonary Disorder (COPD) patient population as they transition from hospital to home to avoid unnecessary re-admission.

- Utilize Electronic Health Records to increase the proportion of patients receiving medication reconciliation upon admission, and expand the process in more areas with the intent to roll-out hospital wide.

Engagement of Leadership, Clinicians and Staff

One of our goals is to engage and empower staff and physicians by developing stimulating environments and ensuring opportunities for participation, leading to improved quality of care and patient satisfaction. The QIP was developed with feedback from staff, managers, the Senior Team, physicians, and the Board of Directors, as well as learnings from our 2015 Accreditation process and the ongoing implementation of our Electronic Health Record.

The process was facilitated by the Quality and Risk department and included a cross-section of leaders, both administrative and clinical, from across the organization. This group worked together to ensure that we are organizationally aligned, committed and appropriately resourced to achieve QIP success.

Our QIP includes a selection of our 6 “Strategies In Action” indicators that are being reported and discussed monthly with Vice Presidents and Directors/Managers. Problem solving tools are used at these monthly discussions to identify specific actions for improvement. Due to competing priorities we are often challenged with sustaining improvements beyond the implementation of solutions. Huddles with Performance Boards have also been introduced in 11 key departments across the hospital, providing a daily communication and idea generation platform for staff.

Patient/Resident/Client Engagement

One of our strategic goals is to improve the delivery of patient inspired care. We will put patients first; measure and improve quality; and improve transitions into and out of hospital. Throughout the year CCH provides quarterly progress reports on the QIP indicators to the Quality & Performance Monitoring Committee of the Board and the Board of Directors. The 2016/2017 QIP was developed with feedback from the Board of Directors and Patient Experience Advisors.

In Q3 of 2015 CCH embarked on a Patient Experience Advisor program to ensure that the voice of the patient is heard and influences planning and decision making on issues that affect patient care, ensuring the needs and expectations of patients and their families are addressed. Advisors are former patients or family members in the past 2 -3 years that are identified and recommended by staff/physicians/volunteers from across the hospital. The eventual goal is to have an advisor for each key area of program delivery.

We also collect patient and family input through a variety of mechanisms including impromptu online surveys, solicited inpatient surveys, the electronic patient incident reporting process, the Patient Relations Specialist, our physicians’ and front-line staff’s day-to-day interactions, and clinical post discharge calls. Due to concerns with NRC surveys, in early 2015 CCH embarked on an in-house process for distribution and analysis of the Canadian Patient Experiences Inpatient Care Survey (Canadian Institute for Health Information {CIHI} product). This process provides more real-time feedback and data analysis for the clinical teams.

The CIHI patient satisfaction survey data has been carefully analyzed to identify areas where our patients are telling us we can do better. As a result of this analysis, we are putting an emphasis on the discharge planning processes with the key goal of ensuring that our patients feel informed and prepared for their next care transition.

Performance Based Compensation [part of Accountability Management]

Cornwall Community Hospital did not have any performance pay during the last performance cycle ending before the "effective date" of March 31, 2012 (2010/2011 performance pay cycle). As stipulated by the Broader Public Services Accountability Act, (2010) (BPSAA), executives within our organization do not have any pay-for-performance tied to the achievement of targets in our 2016/2017 QIP.

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Melanie Baker Brown Board Chair	Christopher M. Giggey Quality and Performance Monitoring Committee Chair	Jeanette Despatie Chief Executive Officer

2016/17 Quality Improvement Plan
"Improvement Targets and Initiatives"

Cornwall Community Hospital 840 McConnell Avenue

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Effective	**Reduce readmission rates for patients with COPD**	Readmission Rate for Patients with COPD (QBP cohort) for same or related diagnosis within 28 days.	% / COPD QBP Cohort	DAD, CIHI / April 2015 - September 2015	967*	19.5	17.00		1)Utilization of Order Sets for standardized care aligning with Best Practice Guidelines (BPG) and Quality Based Procedure (QBP) Hanbook.	With the implementation of Cerner Electronic Health Record, physicians will be required to order COPD order set	Number of COPD Order Sets / Number of patients admitted with COPD X 100 (for percentage)	COPD readmission rates less than 17% by March 31st 2017;(Actual Rate/Target should reflect HSAA target)	
									2)Through Cerner, all patients will receive individualized discharge instruction sheets that include medications, prescriptions, follow-up appointments, as well as community referrals.	All COPD patients will receive standardized teaching from the interdiscpiplinary team as well as written discharge instructions, including smoking cessation follow-up number, utilization of inhalers, medications, referrals and follow-ups	Number of documented discharge information instructions given to COPD patients on discharge / total number of COPD patients discharged (exluding deaths and transfers to other acute facilities) X 100 (for percentage)	COPD readmission rates less than 15% by March 31st 2017;Actual Rate/Target should reflect HSAA target)	
									3)Collaborative model with Seaway Valley Community Health Center (SVCHC) to optimize the use of both hospital and community-based COPD follow-up clinics	Joint collaboration and revision of decision tool for referrals to CCH outpatient COPD clinic verses SVCHC COPD clinic. Jointly, a process will be designed and implemented to facilitate the involvement of COPD Outreach Team with patient in hospital prior to discharge.	Number of patients referred to each program meeting the designated scoring criteria / total number of patients referred X 100 (for percentage)	COPD readmission rates less than 15% by March 31st 2017;(Actual Rate/Target should reflect HSAA target)	
									4)Increased referrals to CCAC Rapid Response Nurse for visit within 1-2 days of discharge	Cerner COPD Order Set will include order for referral to rapid response nurse on admission will support increased uptake of referrals and patients seen.	Number of COPD patients referred to Rapid Response Nurse / Total Number of COPD discharges X 100 (for percentage)	COPD readmission rates less than 15% by March 31st 2017;Actual Rate/Target should reflect HSAA target)	
Efficient	**Reduce unnecessary time spent in acute care**	Total number of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his or her treatment, divided by the total number of inpatient days in a given period x 100.	% / All acute patients	DAD, CIHI / October 2014 – September 2015	967*	16.5	18.00	ALC Rate - Current Performance is based on Q1 and Q2 of this fiscal year (2015-2016). Target is based on LHIN HSAA specifications for 15-16, will be confirmed with release of new HSAA. Fiscal year 15-16 Q1 performance was 19.0%, above target.	1)Sustain weekly inter-agency joint discharge review meetings to review all ALC and ALC bound patients, as well as complex discharges to ensure all services are optimized to support return to community	Continue pre-established weekly meeting that is also used to educate staff on new programs, initiatives, discharge options	ALC volumes; ALC for Long Term Care; ALC Long-Stay patients	Decrease ALC rates, number of beds days occupied by ALC patients and improved performance on ED wait time measures for admitted patients specifically.	

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									2)Formalize a coordinated rapid response between, CCAC, Geriatric Emergency Management and Discharge Planning Nurses for the ED for patients not requiring admission for acute care reasons, yet challenges with available resources to support discharge back to the community and avoid hospitalization and functional decline	Work with CCAC leadership and Director of Patient Access and Community Liaison to formalize the process, including escalation process for avoidable admissions and admissions with inability to cope or needing LTC. Subsequently provide education to ED physicians and staff to support not admitting patients for non acute care reasons until all options have been exhausted by CCAC leadership.	Number of patients admitted through ED with ALC designation on admission or within 48 hours of admission	Decrease ALC rates, number of beds days occupied by ALC patients and improved performance on ED wait time measures for admitted patients specifically.	
									3)Increase compliance with the Barthel Screening on admission and discharge to monitor functional decline in hopsital (further supported with Cerner EHR)	Barthel Screening Tool is built into Cerner for easy access on admission and discharge to support compliance on admission and discharge.	Barthel Screening Tool completion on both admission and discharge / total qualifying patients X 100 (for percentage)	Decrease ALC rates, number of beds days occupied by ALC patients and improved performance on ED wait time measures for admitted patients specifically.	
									4)Increase referrals to Health Links for targetted population to support disease self-management and coordinated care in the community	Increased collaboration and case reviews with Health Links Co-ordinators to ensure those resources are maximized for appropriate patients	Number of patients referred and accepted as Health Links clients	Decrease ALC rates, number of beds days occupied by ALC patients and improved performance on ED wait time measures for admitted patients specifically.	

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Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
Patient-centred	**Improve patient satisfaction**	"Using any number from 0-10 where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your hospital stay?". Add the number of positive responses (including 6-10) and divide by number of respondents who registered any response to this question (do not include non-respondents).	% / All acute patients	In-house survey / October 2014 - September 2015	967*	83.6	87.00	Target increased by 5% (from previous target) as it involves many departments and staff, and is more difficult to improve at higher rates.	2)Switch from NRC Picker surveys in the ED to OHA recommended provider when bidding process is complete.			Highlight changes in results since last quarter; celebrate the best result; Celebrate worst result if improved from last quarter; Stimulate problem solving/ideas to improve on worst result, and track progress on implementation	Internal patient experience surveys will provide CCH with feedback that allow for the hospital to take action on improvement initiatives suggested by patients and families. This supports CCH's strategic direction of creating exceptional Patient Inspired Care.
									3)Patient Experience Advisor (PEA) program is fully functional and integrated into the organization.	Goal is to ensure that the voice of the patient is heard and influences planning and decision making on issues that affect patient care, ensuring the needs and expectations of patients and their families are addressed. Advisors are former patients or family members in the past 2 -3 years that are identified and recommended by staff/physicians/volunteers from across the hospital. The eventual goal is to have an advisor for each key area of program delivery.			Patient Experience Advisor (PEA)will provide CCH with feedback that allow for the hospital to take action on improvement initiatives suggested by patients and families. This supports CCH's strategic direction of creating exceptional Patient Inspired Care.
Safe	**Increase proportion of patients receiving medication reconciliation upon admission**	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	Hospital collected data / most recent quarter available	967*	90	90.00	Current performance is based on Q1 and Q2 of current fiscal year (15-16).	1)Improve medication reconciliation compliance for mental health inpatients	a)Utilizing efficiencies from implementing Cerner system that will allow for easier medication reconciliation by physicians b)Educating mental health physicians on value and importance of medication reconciliation	a)Build reconciliation as part of the phycisians work flow to order home meds will improve medication reconciliation b)discussions at department's meetings	Achieve reconciliation compliance of 90%	Current reconciliation compliance for mental health is at 50% compared to 90% institution wide

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Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired CDI during the reporting period, divided by the number of patient days in the reporting period, multiplied by 1,000.	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / January 2015 – December 2015	967*	0.51	0.30	Current Performance based on Q2 of current fiscal year (2015-2016). 15-16 target set at 0.0 based on LHIN HSAA specifications for 15-16. New target will be verified by 16-17 HSAA.	1)Maintain current practices in relation to surveillance, monitoring, environmental cleaning, hand hygiene and antimicrobial stewardship	Current practices are based on PIDAC guidelines to reduce incidence of hospital-acquired infections and monitored through the Infection Prevention and Control Committee	Maximum of 1.5 hospital-acquired cases of C. difficile monthly	Long term goal is 0 per 1,000 patient days	Long term goal is 0 per 1,000 patient days
									2)Continue to report hand hygiene and c-diff rates monthly in patient care areas	a) Hand hygiene and c-diff rates to target by unit are reported monthly	Monthly reports include discussion of corrective actions required to meet or exceed target when below target	To meet or exceed target for hand hygiene and c-diff rates	Inadequate hand hygiene is recognized as a factor in hospital-acquired infections
									3)Antimicrobial Review	Pharmacy Stewards participate in ICU rounds daily. Pharmacist makes antibiotic recommendations (stop, change route or drug)	Acceptance of recommendation rate. Decline of recommendation rate. Revision of recommendation rate.	Increase Acceptance rate. Decrease decline recommendation rate. Increase in rate of physician revised acceptance of recommendation rate.	ICU is targeted area due to high antimicrobial use. Pharmacist antimicrobial review is key to supporting appropriate antimicrobial use in all areas.
									4)Annual Review of antibiogram.	Microbiology department collects CCH specific drug antibiotic resistance data to produce antibiogram report	Antibiogram is available for physicians via CCH intranet	Physicians have access to CCH antibiogram reflecting local resistance patterns	Knowledge of local resistance patterns supports appropriate antimicrobial prescribing.
		Ventilator-associated pneumonia (VAP) rate per 1,000 ventilator days: Total number of newly diagnosed VAP cases in intensive care units (ICU) after at least 48 hours of mechanical ventilation during the reporting period, divided by the number of ventilator days in that reporting period, multiplied by 1,000.	Rate per 1,000 ventilator days / ICU patients	Publicly Reported, MOH / Jan 2015 - Dec 2015	967*	0	0.00	Current Performance based on Q1 and Q2 of current fiscal year (2015-2016). Performance was the same for fiscal year 2014-2015.	1)Maintain current practices in relation to surveillance, monitoring, and hand hygiene	Current practices are based on PIDAC guidelines to reduce incidence of hospital-acquired infections and the SHN and CCIS VAP bundle toolkits and monitored through the Infection Prevention and Control Committee and ICU Committee		Goal is 0.00	
									2)Consistent application of VAP prevention bundle (checklist) reviewed daily at multidisciplinary rounds	VAP incidents are reviewed by the multidisciplinary team to identify point of transmission and/or opportunity for improvement		Daily review at multidisciplinary rounds	
									3)Continue to report hand hygiene monthly		To meet or exceed target for hand hygiene	80%	Inadequate hand hygiene is recognized as a factor in hospital-acquired infections

AIM		Measure							Change				
Quality dimension	Objective	Measure/Indicator	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Goal for change ideas	Comments
	Reduce rates of deaths and complications associated with surgical care	Number of times all three phases of the surgical safety checklist were performed ('briefing', 'timeout' and 'debriefing') during the reporting period, divided by the total number of surgeries performed in the reporting period, multiplied by 100.	% / All surgical procedures	Publicly Reported, MOH / Jan 2015 - Dec - 2015	967*	99.5	99.60		1)Auditing Safe Surgery Checklist for compliance and completeness	Random audits of surgeries and different services. Incomplete SSCL requires an incident report. Future state - with Cerner, charting will help prompt this activity.	Use of audit tool developed and tailored to CCH	Goal is to complete 5 audits per month.	Completing the SSCL is currently outlined in our policies.
									2)Educate key staff, Managers, Physicians using Standardization/ Expectations video	Educate Nurse champion, Physician champion, Clinical Resource Nurse, OR Manager	Improvement in the SSCL utilization verified by audit	Education video provided to staff listed to standardize SSCL utilization to avoid missing a section or relying on memory	
Timely	**Reduce wait times in the ED**	ED Wait times: 90th percentile ED length of stay for Admitted patients.	Hours / ED patients	CCO iPort Access / January 2015 - December 2015	967*	29.1	35.00	Current Performance based on Q1 and Q2 of current fiscal year (15-16). Target set according to LHIN HSAA specifications, to be confirmed/adjusted according to 16/17 HSAA.	1)Introduce daily 'take one patient' strategy in programs to facilitate patient flow	Daily 'pull one' of one appropriate admitted patient from the ED to designated space on inpatient units	One appropriate patient pulled from ED to other inpatient unit(s) each morning	Implement 'pull one' 7-days per week and establish baseline measures for future improvements	
									2)Optimize staffing models & schedules	Change staff model in Day Surgery and Recovery Room to minimize Day surgery patients from being held overnight, freeing up space for ED patients	Schedules optimized	New Schedules in place by Q3 of 16/17	
									3)Increase adherence and accountability for Bed Management and Bed Assignment policies and guidelines.	Simplify policies , provide short Standard Operating Procedures for staff to follow	Performance and adherence will be reviewed monthly by dept Directors, & quarterly by the Senior Leadership Team & Quality, Monitoring & Performance Committee of the Board.	Policies revised and SOPs complete in Q3	
									4)Continue focus on time-to-inpatient bed, i.e., Continuous Improvement Project on Predictive Discharges Discharge Preparedness Documentation Tool, MD rounds on Medicine, Bullet Rounds 7 days/week.				
									5)Continue to refine process for Geriatric Emergency Management Nurses and CCAC interventions to prevent admissions for patients not requiring acute hospital care.	Trying not to admit, doing a general consult, working with CCAC and keeping patient for 24 hrs , but prevents long term admission			
									6)Support real-time admissions and decrease batching to support patient flow out of ED 24/7.	Housekeeping can be bottleneck and schedules for staffing need to be looked at			