Cornwall Community Hospital
Hôpital communautaire de Cornwall

QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2023/2024

Vision: Exceptional Care. Always.

Mission: Our Team collaborates to provide exceptional patient-centered care

Values: *ICARE* *Integrity - Compassion - Accountability - Respect - Engagement*

Instructions: Clicking on the indicator takes the user to additional supporting details.

RECOVERY					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	G	G	G	
Repeat ED Mental Health Visits	QIP/HSAA/MSAA	G	G	G	

INTEGRATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	Y	G	G	
Medication Scanning Compliance	QIP	R	R	R	
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	Y	G	Y	

PEOPLE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Workplace Violence Prevention - Incidents	QIP	Y	G	R	

Results:

Metric underperforming target	R
Metric within 10% of target	Y
Metric equal to or outperforming target	G
Data not available	N/A

Overall Indicator Performance:	Q1	Q2	Q3	Q4
% Indicators equal to or outperforming targets:	33%	83%	50%	
% Indicators within 10% of targets:	50%	0%	17%	
% Indicators underperforming targets:	17%	17%	33%	

Reference Definitions:

Accreditation - Accreditation Canada
Board - Board Directed
HSAA - Hospital Services Accountability Agreement
MoHLTC - Public Reporting Requirement; Ministry directive
MSAA - Multi-Sector Service Accountability Agreement
OPT - (Annual) Operating Plan Target
Senior Friendly - Senior Friendly Initiative (HSAA)
QIP - Quality Improvement Plan

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Inpatient Bed (TIB)

Strategic Direction: RECOVERY

Definition: This is a mandatory QIP indicator. The indicator is measured in hours using the 90th percentile, which represents the time interval between the Disposition Date/Time Patient Left the Emergency Room Department for admission to an Inpatient bed or Operating Room.

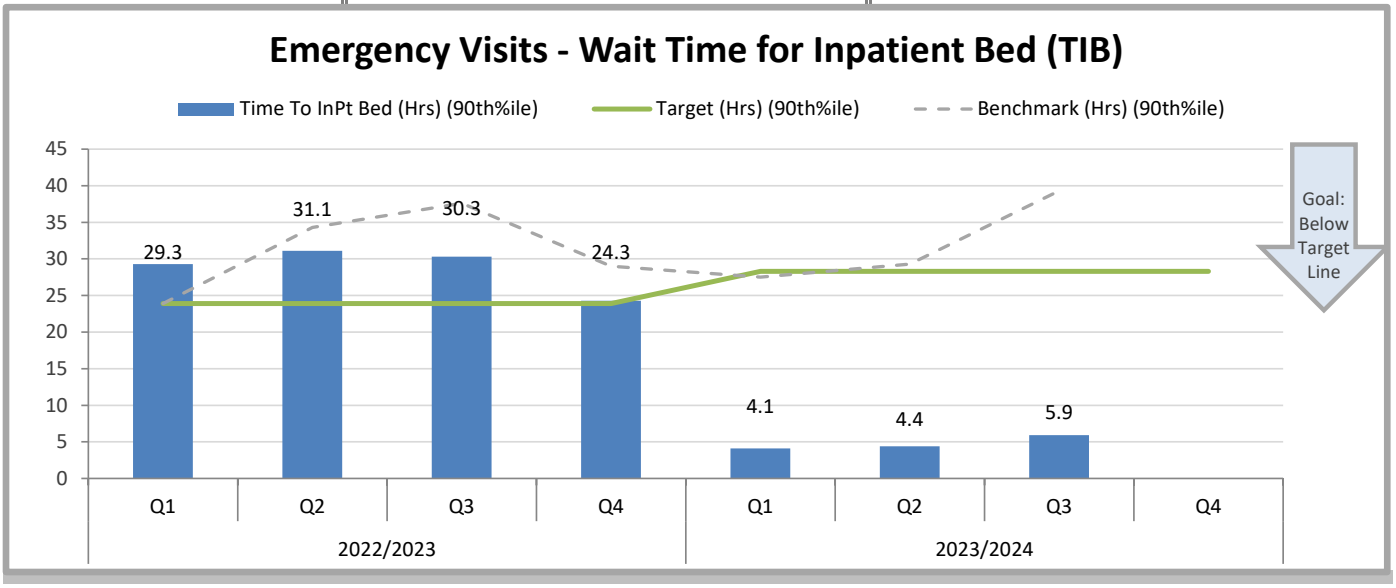
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. The 90th percentile of this indicator represents the maximum length of time that 90% of patients in the ED wait for an inpatient bed or an operating room in the ED.

Data Source: Anzer - NACRS

Target Information: Target set in accordance to QIP indicator.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	29.3	31.1	30.3	24.3	4.1	4.4	5.9	
Benchmark (Hrs) (90th%ile)	23.9	34.3	37.6	29.0	27.5	29.3	39.3	
Target (Hrs) (90th%ile)	23.9	23.9	23.9	23.9	28.3	28.3	28.3	28.3



Performance Analysis:

Q1 Target met. ED flow is a standing agenda item for our ED working group. ED processes are continuously monitored and recommendations for improvement are implemented by ED flow nurse. □

Q2 Target met. We continue to trend within target and benchmarking peers.

Q3 Target met. Q3 had a slight increase however we continue to be within target.

Q4

Plans for Improvement:

Q1 The ED working group continues to analyze ED flow for potential improvements.
Continue to work closely with patient flow and Inpatient Units.
We expanded our ED flow nurse scope and increased our flow nurse coverage.
We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED. □

Q2 The ED Working Group continues to analyze ED patient flow for potential improvements. We continue to work closely with Patient Flow and Inpatient Units. We maintained our Flow Nurse coverage.

Q3 The ED Working Group continues to analyze ED patient flow for potential improvements. We continue to work closely with Patient Flow and Inpatient Units. We have expanded our ED Flow Nurse coverage.

Q4

Accountable: Chief of Information and Operating Officer / Manager, Acute Medicine

Return to Dashboard

Indicator: Repeat ED Mental Health Visits

Strategic Direction: RECOVERY

Definition: The percentage of repeat emergency visits (for a mental health or substance abuse condition) following an emergency visit for a mental health condition. The repeat visit must be within 30 days of the 'index' visit (first visit). This is based on the Most Responsible Diagnosis (mental health codes - ICD-10) and includes only CCH cases.

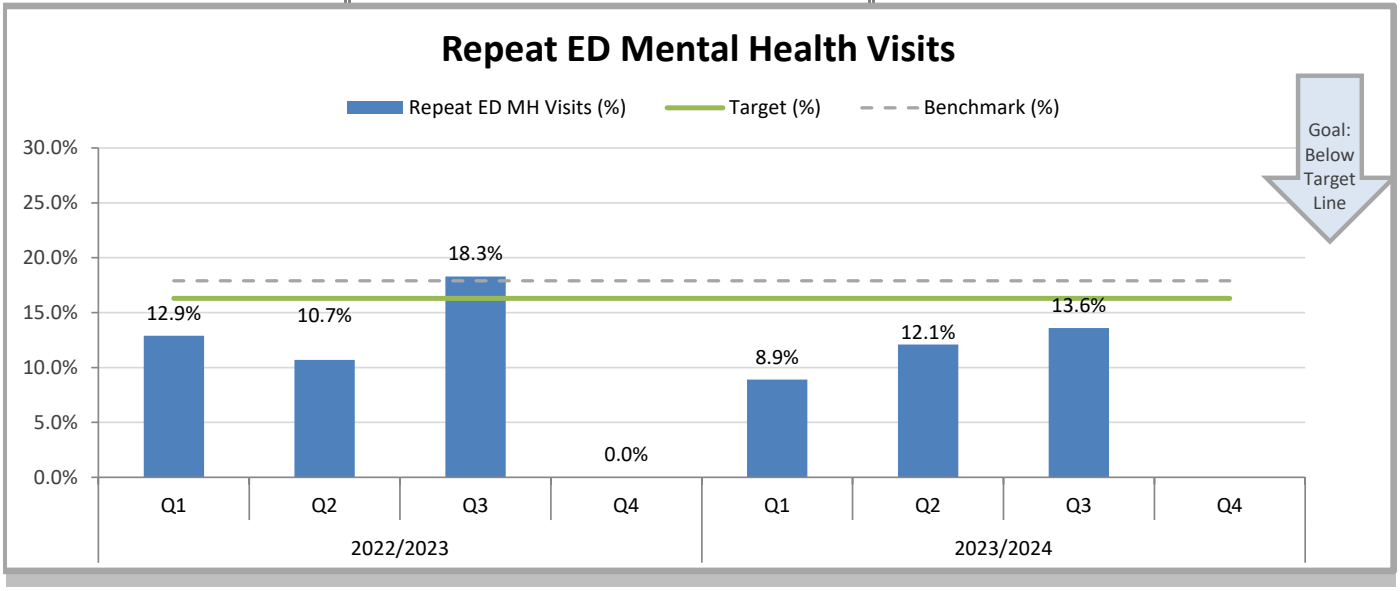
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions, access to effective community services should reduce the number of repeat unscheduled emergency visits. This indicator attempts to indirectly measure the availability and quality of community services for patients with mental health conditions. Investments in community mental health services such as crisis response and outreach, assertive community treatment teams, and intensive case management are intended to provide supports to allow individuals with mental illness to live in the community (CMHA, 2009; Every door is the right door, 2009). This indicator also supports the future development and improvement of data collected that could be used to directly measure the quality and availability of community mental health especially relating to wait times.

Data Source: Anzer - NACRS (National Ambulatory Care Reporting System)

Target Information: Target to align with 2018-2019 HSAA and MSAA

Benchmark Information: Based on Champlain LHIN 2017/18 Q2 - Appendix A results as reported in Champlain LHIN Measuring Performance Second Quarterly Report 2017-18 January 2018

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	12.9%	10.7%	18.3%	N/A	8.9%	12.1%	13.6%	
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%



Performance Analysis:

Q1 Results unavailable due to Cyber Incident and system failure (Anzer).

Q2 Data available for Q1 and Q2. Q1 results show 271 ED indexed visits with 24 returns representing 8.9% and falling within suggested target. Q2 results show 265 ED indexed visits with 32 returns representing 12.1% and within suggested target.

Q3 Target met. Q3 continues to trend upwards compared to previous quarters however we continue to be below target.

Q4

Plans for Improvement:

Q1 Anzer software has been recovered. Processes in place to recover and submit backlogged data for Q1 and Q2 reporting.

Q2 Performance within target. Will continue to work with ED Social Work, Inpatient Mental Health services, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits.

Q3 Will continue to work with ED Social Work, Inpatient Mental Health services, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits.

Q4

Accountable: Chief of Information and Operating Officer / Manager, Emergency Department

Return to Dashboard

Indicator: Discharge Summary Sent from Hospital to Primary Care Provider Within 48 Hours of Discharge

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider (PCP) within 48 hours of patient's discharge from hospital.

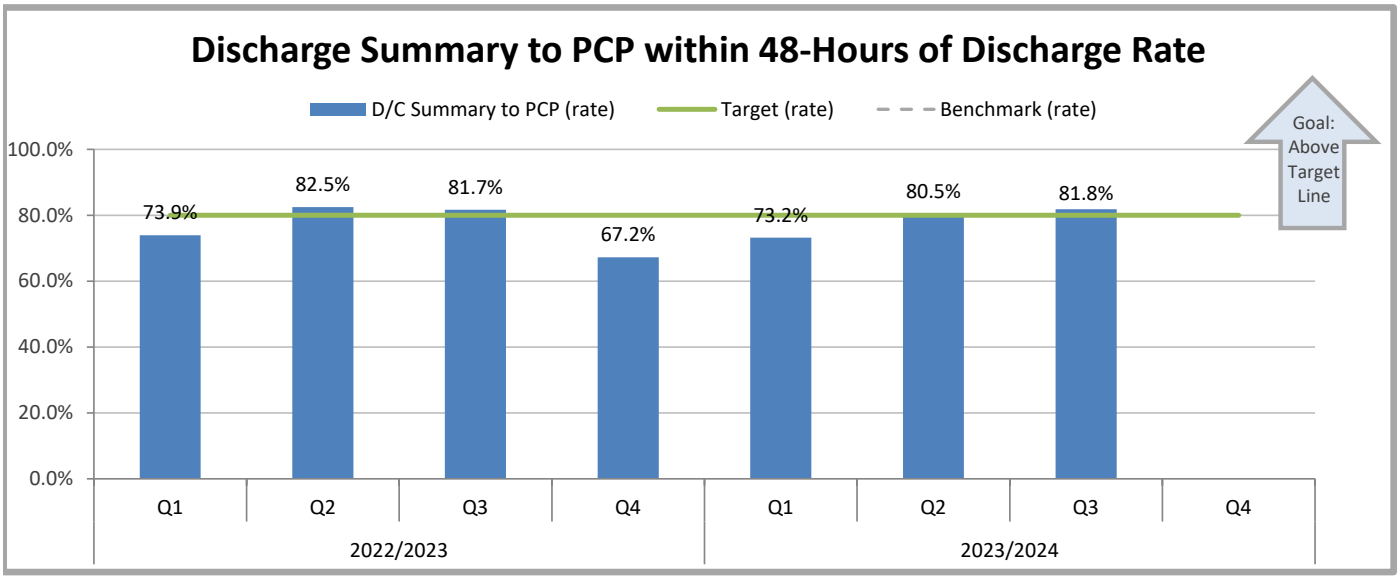
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow-up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up."

Data Source: Cerner - Discern Analytics, Electronic Health Record

Target Information: Target is set internally at 80.0% in accordance to QIP indicator

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	73.9%	82.5%	81.7%	67.2%	73.2%	80.5%	81.8%	
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Target not met. Lack of VPN access may contributed to the performance level.
There were a total of 1339 applicable discharges with 980 completed within 48 hours.

Q2 Target met. There were a total of 1291 applicable discharges with 1039 completed within 48 hours.

Q3 Target met. Q3 had a total of 1294 applicable discharges with 1059 completed within 48 hours. Q3 continues to trend upwards.

Q4

Plans for Improvement:

Q1 Encourage physicians to complete their mandatory documentation within 48-hours while on site until VPN access is available.
Working to reestablish remote access (started first week of September).
Working towards introduction of a new tool (Power Chart Touch) which should allow physicians to complete their documentation remotely in a very convenient way. Expected to go live Q3.

Q2 VPN has been reestablished for most physicians. Continue to monitor and encourage physicians to complete their mandatory documentation within 48 hours.

Q3 Powerchart Touch (Cerner mobile app) is live for physicians; we will be evaluating its utilization for documentation purposes and the impact on this metric.
HIS will continue to email physicians daily who have outstanding discharge summaries that are within 48 hours of discharge

Q4

Accountable: Chief Information and Operating Officer / Manager, Health Information Services

QIP Scorecard FY 2023/2024

Return to Dashboard

Indicator: Medication Scanning Compliance

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of medication administered for which a medication scan was completed for all inpatient and emergency department patients (Excludes Outpatient, Day Surgery, Ambulatory Care).

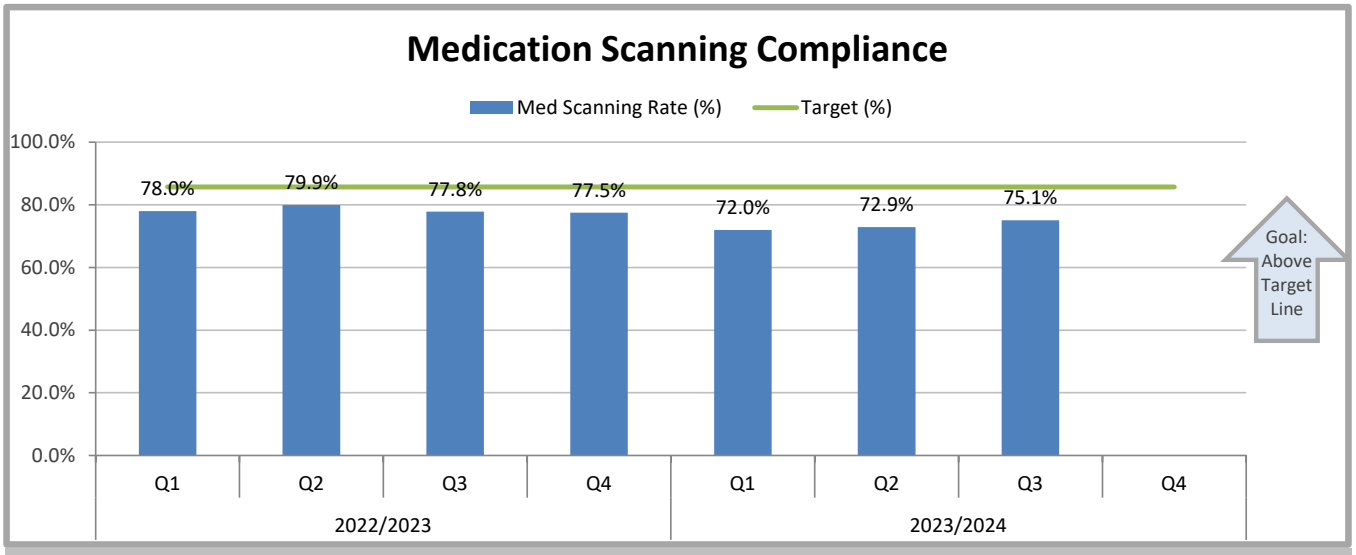
Significance: Barcode medication administration (BCMA) systems scan a patient's wristband and medication to be given in order to prevent medication errors. BCMA has shown to reduce medication administration errors significantly and to reduce harm from serious medication errors.

Data Source: Cerner Reporting Portal

Target Information: Set internally at 85.7% in accordance to QIP indicator

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Scanning Rate (%)	78.0%	79.9%	77.8%	77.5%	72.0%	72.9%	75.1%	
Benchmark (%)								
Target (%)	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%



Performance Analysis:

Q1 Target not met. Gathering additional data for analysis of performance.

Q2 Target not met. All locations fall below target.

Q3 Target not met. All nursing units continue to fall below target, however, the compliance rate continues to move in the right direction.

Q4

Plans for Improvement:

Q1 In Q1 evaluation of medication scanning override options based on best practices was completed and approved; education to follow. Technology assessment currently underway to ensure no operational gaps. Plan to engage end users through CI Council in Q2 to further understand gaps in compliance.

Q2 In Q2, environmental scan of medication administration locations was completed and plan was put in place to ensure medication scanners are available in locations with current gaps. Continue to educate on reporting medication scanning issues. Plan to continue to engage end users through huddles to further understand continued gaps in compliance. Will highlight importance of closed loop medication in Q3 through CI Newsletter.

Q3 In Q3, the importance of medication scanning in relation to patient safety was presented to clinical leadership. An infographic was developed and distributed re: medication scanning and patient safety implications; clinical managers were requested to huddle with staff to review. Work is being completed to improve communication between pharmacy and CI when new products are received/barcodes change to ensure products are updated prior to being distributed to the clinical units.

Q4

Accountable: Chief Information and Operating Officer / Chief of Staff

Return to Dashboard

Indicator: Accreditation Canada Required Organizational Practice (ROP) - Medication Reconciliation on Discharge Rate

Strategic Direction: INTEGRATION

Definition: This is a priority indicator; medication reconciliation at care transition has been recognized as best practice, and is an Accreditation Required Organization Practice. Total number of discharged patients with completed Medication Reconciliation divided by the total # of discharged patients. (Excludes - Interfacility Transfers, Deaths, ED Hold, PACU, Obstetrical and Newborn patients).

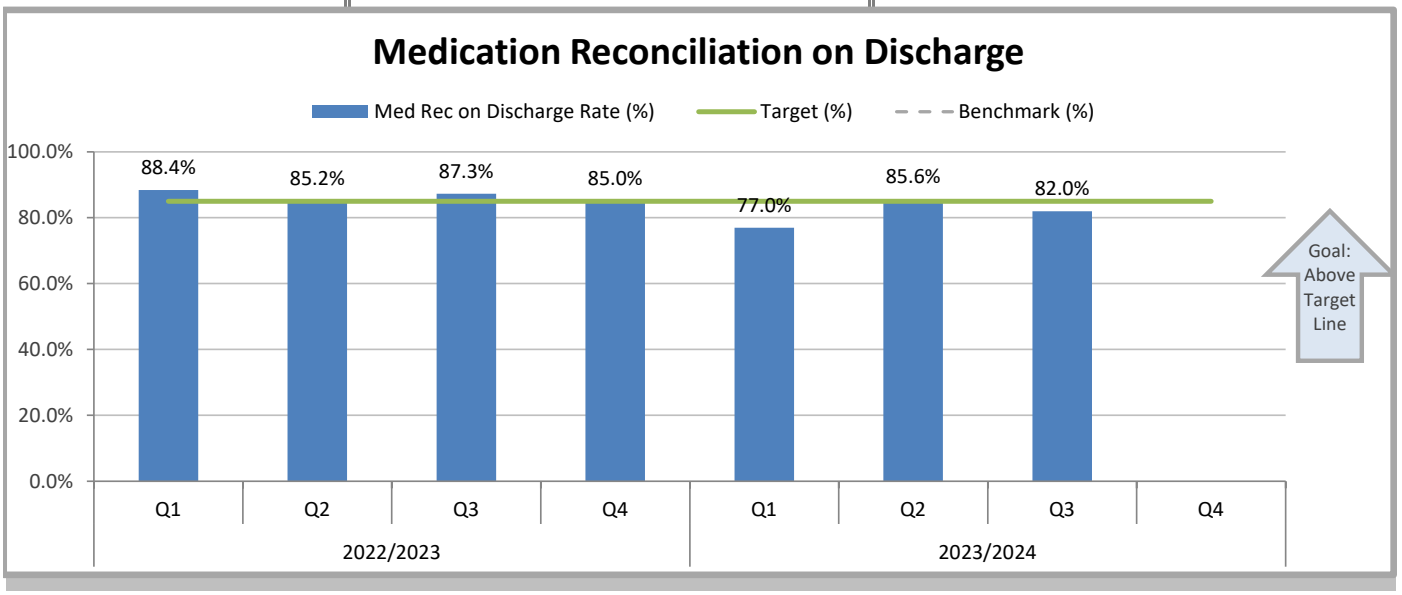
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient (Safer Healthcare Now! Medication Reconciliation in Acute Care Toolkit, Sept 2011).

Data Source: Cerner electronic health record

Target Information: Set internally at 85% in accordance to QIP indicator

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	88.4%	85.2%	87.3%	85.0%	77.0%	85.6%	82.0%	
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met this quarter due to the impact of the Cyber Incident on April results. Although results are 10% lower than prior quarters, the monthly results for Q1 are trending in the right direction showing Apr, May, June results of 62.7%, 81.0%, 85.3% retrospectively.

Q2 Target met overall. All locations within target, except for Level 6 WCH (70%) and Level 2 Surgery (78%).

Q3 Target not met. Monthly results are within 5% of meeting target and trending upwards each month.

Q4

Plans for Improvement:

Q1 Inpatient Surgery and WCH are the two focus areas this quarter. Inpatient Surgery Manager will discuss the unit's med rec on discharge rate at the OR committee scheduled September 12th, 2023. As well, this will be brought forward to Chief of Surgery in hopes to identify opportunities with the group. Both Inpatient Surgery and WCH will examine the data of incomplete med recs at discharge to identify trends and opportunities.

Q2 In Q2, both Level 2 Surgery and Level 6 WCH remain below target this quarter. To continue working with units below target to educate on importance with appropriately completing Med Rec at Discharge. Plan to continue engaging MRPs through meetings and discussions to further understand ongoing gaps in compliance and identify improvement strategies for the next quarter.

Q3 For units that fall below target, department chiefs will be provided Med Rec on Discharge to identify opportunities and barriers with completion.

Q4

Accountable: Chief Information and Operating Officer / Chief of Staff

Return to Dashboard

Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: PEOPLE

Definition: This is a mandatory QIP indicator. The number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period. Directive of Improvement is focused on building our reporting culture to increase the number of reported incidents.

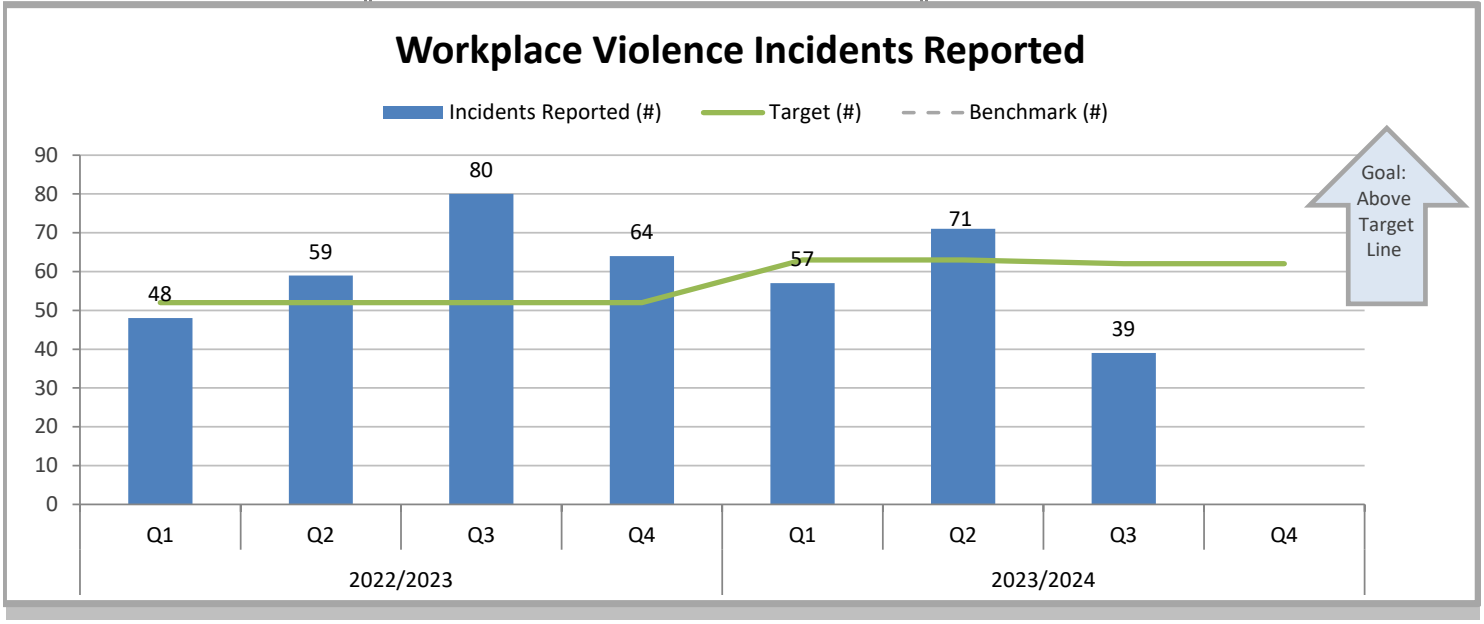
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like other injuries, injuries from violence are preventable. Reporting all incidents is done for the purpose of identifying priorities for intervention to reduce hazards.

Data Source: RL Solution -Incident Management System

Target Information: Target is set internally at 62.5 per quarter (total of 250 annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	48	59	80	64	57	71	39	
Benchmark (#)								
Target (#)	52	52	52	52	63	63	62	62



Performance Analysis:

Q1 Results slightly below target this quarter with 57 reported incidents due to Cyber Incident and lack of RL Solution

Q2 Target met.

Q3 Taget not met. October (7 incidents) and December (5 incidents) having lower reported incidents are contributing to target not being met for Q3.

Q4

Plans for Improvement:

Q1 Continue to work on recovery of RL Solution. Violence & Harassment subcommittee of the Joint Health & Safety Committee will be meeting in September to schedule Violence reporting awareness education at departmental team huddles. Currently reviewing the Code White process for opportunities for reporting improvements.

Q2 Continue with current strategy.

Q3 Reporting was below target mainly due to the requirement of manual reporting as the RL Solution system is being rebuilt.

Q4

Accountable: Chief Human Resources Officer / Manager, Human Resources

Return to Dashboard