Cornwall Community Hospital
Hôpital communautaire de Cornwall

QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2024/2025

Vision: Exceptional Care. Always.

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

Values: *I C A R E 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 Physician Initial Assessment (PIA)	QIP	G	R	Y	

INTEGRATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Patient Satisfaction Survey	QIP	G	G	G	
Medication Scanning Compliance	QIP	R	Y	Y	

PEOPLE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Equity, Diversity, Inclusion and Anti-Racism Education	QIP	R	R	G	

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:	50%	25%	50%	
% Indicators within 10% of targets:	0%	25%	50%	
% Indicators underperforming targets:	50%	50%	0%	

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

QIP Scorecard FY 2024/2025

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Physician Initial Assessment (PIA)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the time interval between the Triage Date/Time or Registration Date/Time and the Physician Initial Assessment and Non-Physician Initial Assessment (PIA / NPIA) Date/Time in the ED. PIA / NPIA includes; Physicians, Physician Assistants, Dentist, and Nurse Practitioner. Exclusions are; Left Without Being Seen (LWBS), Missing PIA Date/Time, Missing Disposition Date/Time and Missing Time Left ED Date/Time as per P4R criteria).

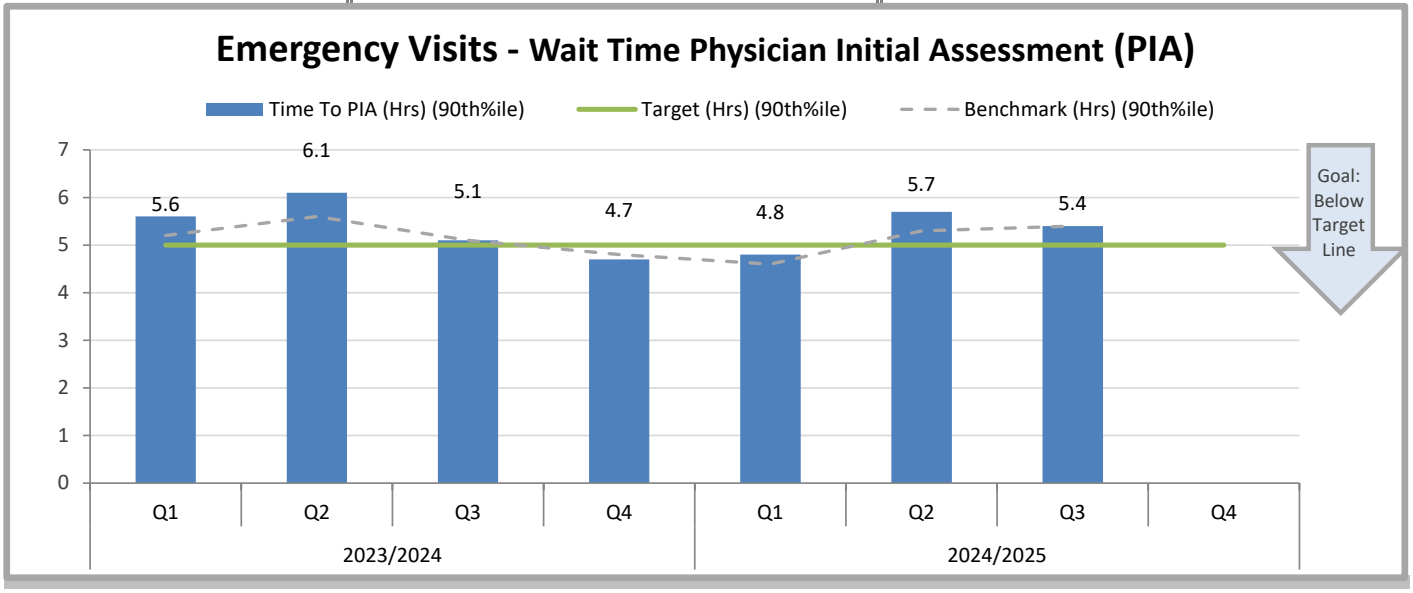
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Multiple factors can influence the indicator results, including triage level, patient population and availability of resources. The 90th percentile of this indicator represents the maximum length of time that 90% of patients waited in the ED for a Physician Initial Assessment (PIA).

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2022-Nov2023) of peer 75 hospital at the 90th percentile.

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

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To PIA (Hrs) (90th%ile)	5.6	6.1	5.1	4.7	4.8	5.7	5.4	
Benchmark (Hrs) (90th%ile)	5.2	5.6	5.1	4.8	4.6	5.3	5.4	
Target (Hrs) (90th%ile)	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0



Performance Analysis:

Q1 Target met. Q1 results are on trend with peers.

Q2 Target not met. All periods for Q2 were above target (Jul. 5.7, Aug. 5.8, Sep. 5.6). However, performance is improving vs the benchmark. Potential impact from summer holidays.

Q3 Target not met. Although we were above target this quarter we align with our peer hospitals.

Q4

Plans for Improvement:

Q1 We continue to optimize the role of our Physician Assistant in the Emergency Department. There has been increased awareness amongst staff and Physicians in the ED. Workflow changes are ongoing to ensure we maintain and improve PIA.

Q2 Continue with our optimization and expansion to ED Flow and Medical Directives utilization.

Q3 We continue to optimize the role of our Physician Assistant in the Emergency Department, in particular when faced with unexpected Emergency Department Physician staffing challenges. Optimization of ED patient flow is ongoing, including evaluation of process improvement initiatives to ensure we maintain and improve PIA.

Q4

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

QIP Scorecard FY 2024/2025

Return to Dashboard

Indicator: Patient Satisfaction Survey

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of Inpatient respondents who responded positively (positive response includes "completely" and "quite a bit") (Top2Box) to "Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?" (Ontario Adult Inpatient Short Form Survey - Question #7).

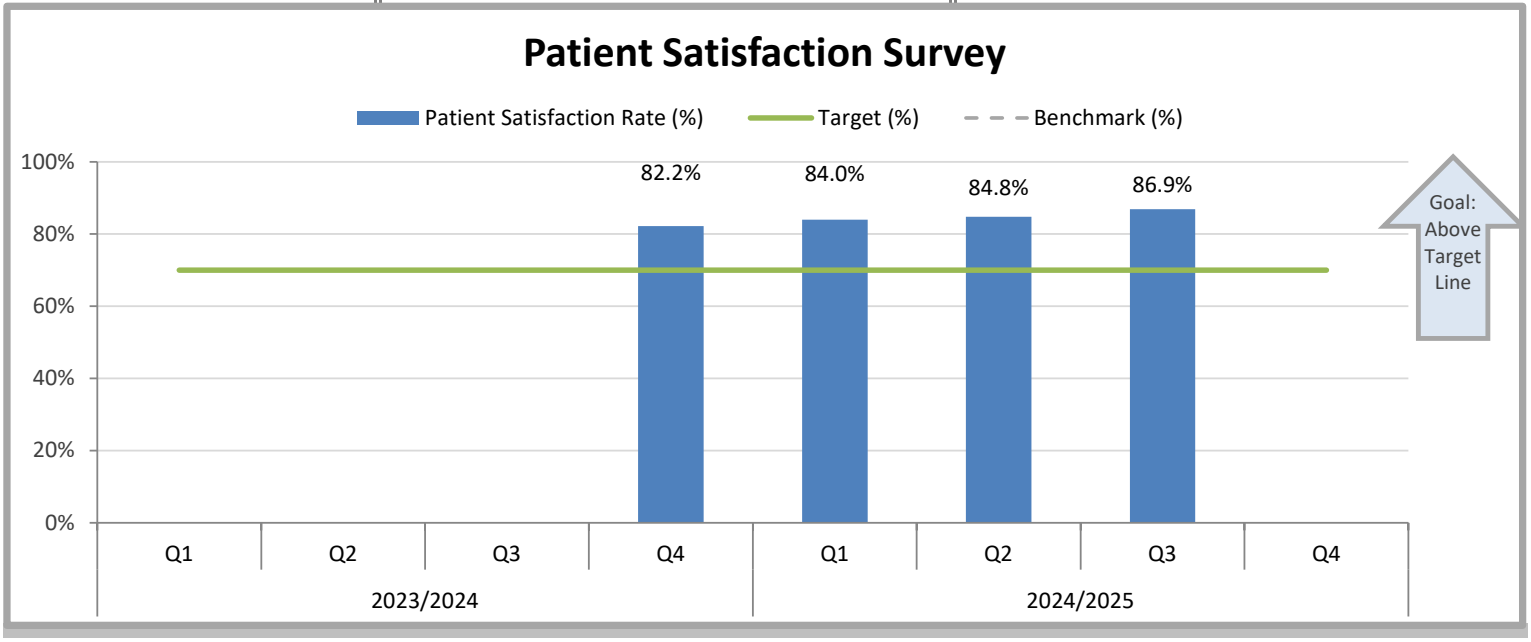
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that is sensitive to patients' concerns and comfort, and that actively involves patients and family members in shared decision-making about their care."

Data Source: Qualtrics

Target Information: Target set in accordance to QIP indicator using Peer Benchmark Hospitals FY20-21 (HQO - QIP Navigator).

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patient Satisfaction Rate (%)	N/A	N/A	N/A	82.2%	84.0%	84.8%	86.9%	
Benchmark (%)								
Target (%)	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%



Performance Analysis:

Q1 Target met. 105 respondents responded positively out of 125 respondents.

Q2 Target met. 89 respondents responded positively out of 105 respondents.

Q3 Target met. 86 respondents responded positively out of 99 respondents.

Q4

Plans for Improvement:

Q1 Will continue to monitor closely. Looking at opportunities to increase our sample size.

Q2 Target met. Continue to monitor action plan (POD's & Manager Patient Rounding) for consistency. Next step to work towards increasing response rates.

Q3 Target met. We continue to monitor our responses and seek immediate feedback through managers rounding with patients and families.

Q4

Accountable: VP, Patient Services and Chief Nursing Officer

QIP Scorecard FY 2024/2025

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).

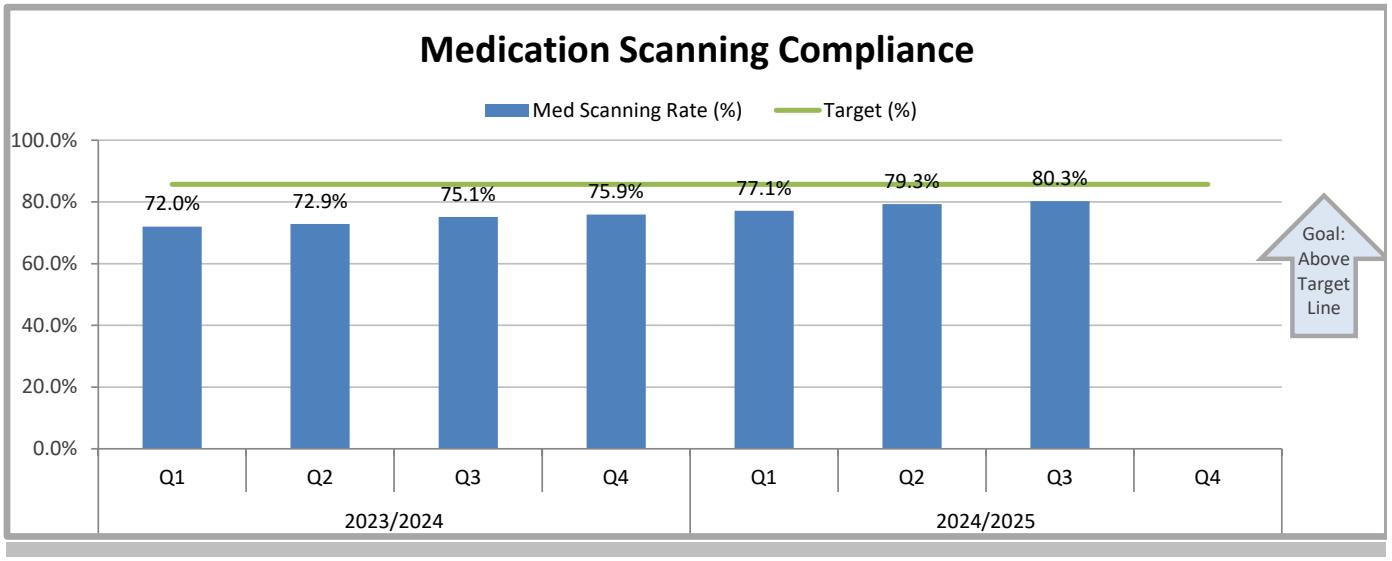
Significance: Barcode medication administration (BCMA) systems scan a patient's wristband and medication to be given in order to prevent medication errors. BCMA has shown to reduce medication administration errors significantly and to reduce harm from serious medication errors.

Data Source: Cerner Reporting Portal

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

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Scanning Rate (%)	72.0%	72.9%	75.1%	75.9%	77.1%	79.3%	80.3%	
Benchmark (%)								
Target (%)	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%



Performance Analysis:

Q1 Target not met. Q1 had 172,084 medications scanned out of 223,283. April and June were within 10% of reaching the target (Apr. 77.5% / Jun. 77.2%).

Q2 Target not met. Q2 had 182,141 medications scanned out of 229,698 with all months being within 10% of reaching target.

Q3 Target not met. We continue to see improvement from previous quarter. There were 202,012 medications scanned out of 251,425. 4 out of the 9 nurse units met target and 1 unit was within 10% of target.

Q4

Plans for Improvement:

Q1 One-on-one coaching sessions were conducted with department managers and directors to review departmental rates and identify potential areas for improvement. One unit exceeded target at the end of Q1. Employee performance recognition for rate improvements is being completed at the departmental level.

Q2 Managers have been meeting with staff starting in the summer and moving through to review scanning rates individually. Should see improvement in Q3.

Q3 Managers continue to run reports and meet with staff, continue to look for medications and IV fluids that cannot be scanned to make improvements. Slight improvement since previous quarter. Need to continue to discuss with staff. To improve in Q4, Pharmacy continues to work on creating "fake bar codes" for products that have lot and exp embedded in their bar codes to enable the products to be scanned by nursing. This is required since Cerner cannot capture the lot and exp. Pharmacy plans to test scanning with CI in more detail.

Q4

Accountable: Chief Information and Operating Officer / Chief of Staff

QIP Scorecard FY 2024/2025

Return to Dashboard

Indicator: Equity, Diversity, Inclusion and Anti-Racism Education

Strategic Direction: PEOPLE

Definition: This indicator measures the percentage of active staff (executive-level, management, and chief of departments) who have completed relevant equity, diversity, inclusion and anti-racism education. Performance is cumulative year-to-date. Excludes supervisors.

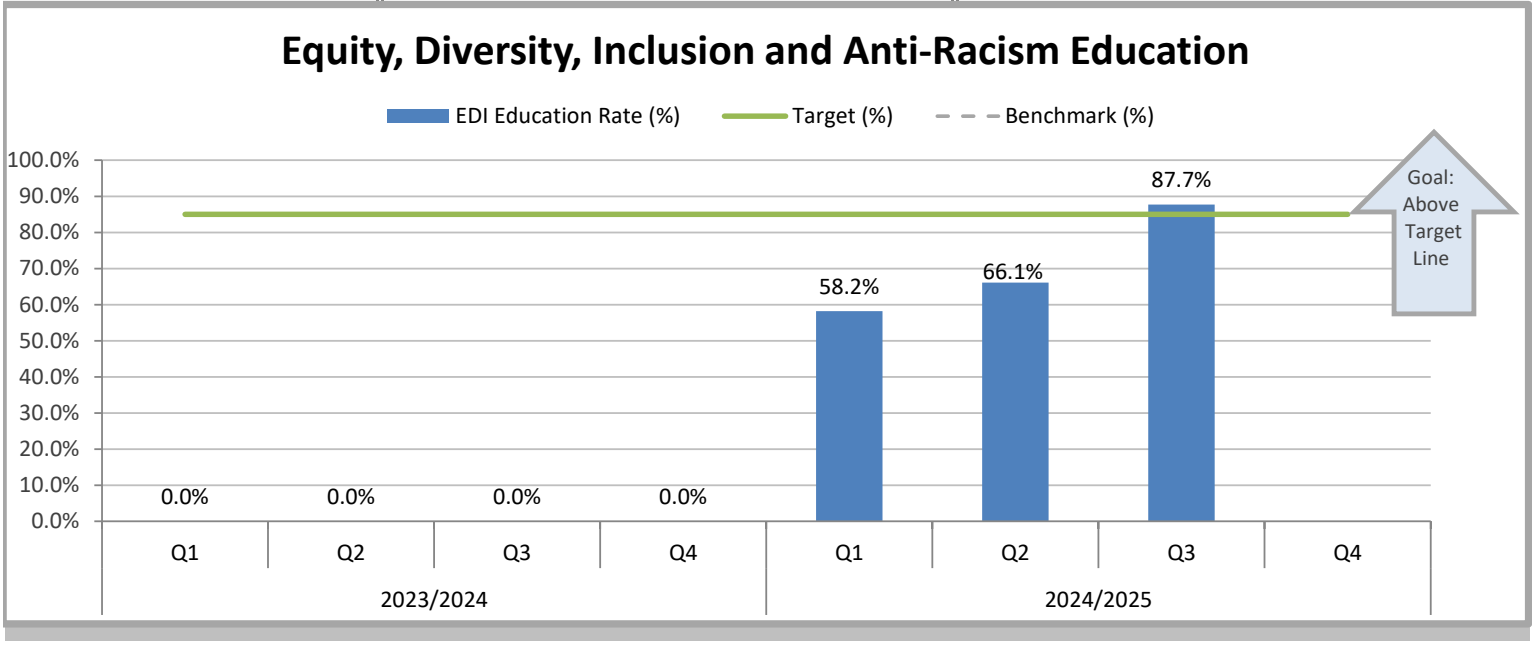
Significance: Education is essential to help guide and build a culture focused on equity, diversity, inclusion, and anti-racism, and to contribute to better outcomes for patients, families, and providers within the health system. The commitment to addressing racism and discrimination, reducing inequities in the health system, and recognizing that our organizational culture needs to be equitable to contribute to better outcomes for the communities we serve.

Data Source: Learning Management System (LMS)

Target Information: Target set in accordance to QIP indicator.

Benchmark Information: N/A

	2023/2024				2024/2025			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
EDI Education Rate (%)	N/A	N/A	N/A	N/A	58.2%	66.1%	87.7%	
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met. 32 staff were compliant with EDI training out of 55.

Q2 Target not met. 39 staff were compliant with EDI training out of 59.

Q3 Target met. 50 staff members were compliant with EDI training out of 57 this quarter. The physician compliance rate increased from 25% to 83% this quarter which was a signifcant factor in meeting target.

Q4

Plans for Improvement:

Q1 Improve communication regarding the importance to complete required training.

Q2 Continue with communication strategies to build a culture focused on equity, diversity, inclusion, and anti-racism.

Q3 Target met. Continue with strategy

Q4

Accountable: Chief Human Resources Officer / Director, Human Resources

Return to Dashboard