



QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2018/2019

Vision: Exceptional Care. Always.

Mission: Our health care 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.

PATIENT INSPIRED CARE						
Indicator	Reference	Q1	Q2	Q3	Q4	
Patient Experience Survey: Rate Care in ED	QIP	Y	G	G	G	
Patient Experience Survey: Information	QIP	G	G	R	Y	
Readmission Rate for (QBP) COPD	QIP	G	G	G	Y	
Complaints Acknowledged	QIP	G	Y	G	G	

Results:

Metric underperforming target

Metric within 10% of target

Metric equal to or outperforming target

Data not available

R
Y
G
N/A

PARTNERING FOR PATIENT SAFETY AND QUALITY OUTCOMES						
Indicator	Reference	Q1	Q2	Q3	Q4	
ROP - Medication Reconciliation on Discharge Rate	QIP/Accreditation	G	G	G	G	

OPERATIONAL EXCELLENCE THROUGH INNOVATION						
Indicator	Reference	Q1	Q2	Q3	Q4	

OUR TEAM OUR STRENGTH						
Indicator	Reference	Q1	Q2	Q3	Q4	
Indigenous Cultural Awareness	QIP/HSAA/OPT	G	G	G	G	
Workplace Violence Prevention - Incidents	QIP	G	G	G	G	

Reference Definitions:

Accreditation - Accreditation Canada

HSAA - Hospital Services Accountability Agreement

OPT - (Annual) Operating Plan Target

QIP - Quality Improvement Plan

Indicator: Patient Experience Survey - Rate Care in ED

Strategic Direction: Patient Inspired Care

Definition: Percentage of Emergency Room respondents who responded positively (numbers 6-10) (Top2Box) to "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 your care during this emergency department visit?" (Question #30).

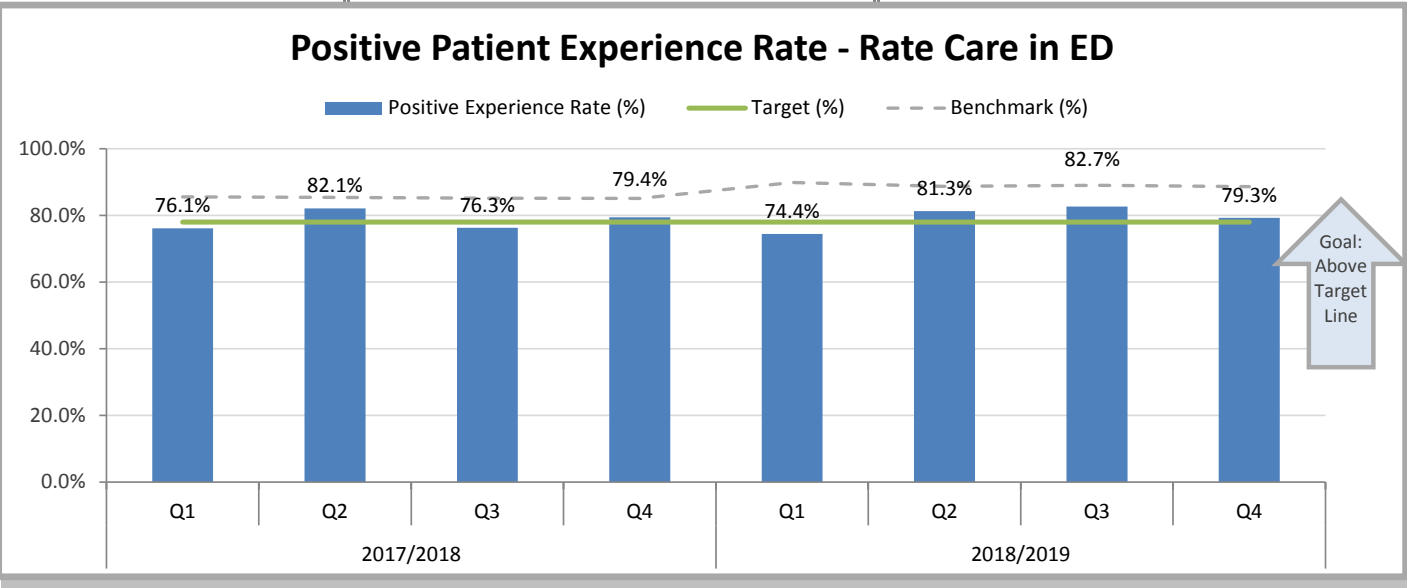
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: NRC (National Research Corporation)

Target Information: Set in accordance to QIP indicator

Benchmark Information: Benchmark performance is based on NRC - Champlain LHIN average quarterly performance

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	76.1%	82.1%	76.3%	79.4%	74.4%	81.3%	82.7%	79.3%
Benchmark (%)	85.6%	85.4%	85.2%	85.1%	89.9%	88.7%	89.0%	88.6%
Target (%)	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

- Q1** No Q1 results available at this time - data submitted for April and May 2018.
- Q2** Q1 results slightly below target. Reporting is one quarter delayed.
- Q3** Above target for Q2 and Q3.
- Q4** Target met for Q4. Survey returned response rate was 22.5% with an annual rate of 23.2%.

Plans for Improvement:

- Q1** Anticipate Q1 data to be submitted for Q2 analysis.
- Q2** Review all comments from completed surveys that have been returned to identify areas for improvement. Several initiatives have been implemented such as the Left Without Being Seen Call-Back Program and the implementation of the Physician Assistant. We are continuing work on improving patient flow in the ED and decreasing the length of stay.
- Q3** Same as above. We continue to respond in a timely fashion to complaints and resolve the issues as soon as possible. Continued efforts to improve wait times in the ED should help us maintain or improve our current performance.
- Q4** Continue as above.

Indicator: Patient Experience Survey - Information Inpatient

Strategic Direction: Patient Inspired Care

Definition: Percentage of Inpatient respondents who responded positively (positive response include "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?" (Question #38)

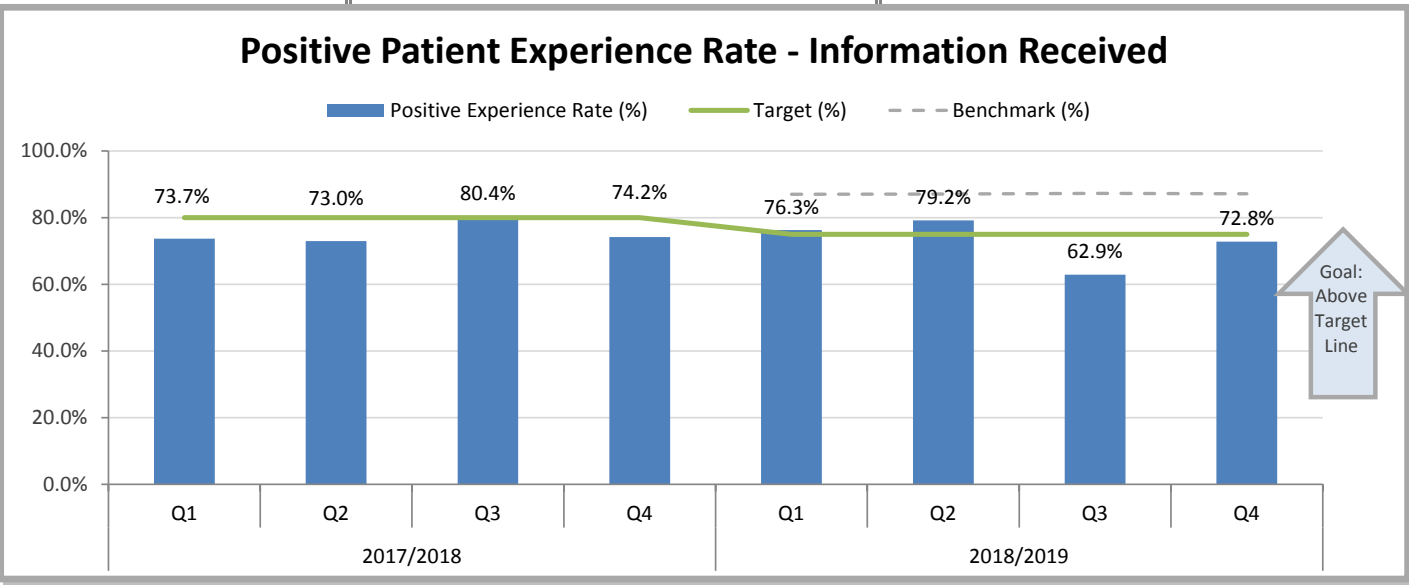
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: NRC (National Research Corporation) (Prior FY1718 from Internal Survey results)

Target Information: Set in accordance to QIP indicator

Benchmark Information: Benchmark performance is based on NRC - Champlain LHIN average quarterly performance

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	73.7%	73.0%	80.4%	74.2%	76.3%	79.2%	62.9%	72.8%
Benchmark (%)					87.0%	87.1%	87.3%	87.2%
Target (%)	80.0%	80.0%	80.0%	80.0%	75.0%	75.0%	75.0%	75.0%



Performance Analysis:

- Q1 No results available at this time - Data submitted for Q1.
- Q2 Q1 results - target met.
- Q3 Q2 target was met. Q3 results are slightly below target.
- Q4 Q4 results slightly below target. Total surveys returned rate for Q4 is 42.9%; with an annual returned rate of 41.3%.

Plans for Improvement:

- Q1 Await results from NRC - no plan at this time.
- Q2 Process for Inpatient Survey changed from internal to NRC Picker. Results reported are from Q1 due to 3rd party outsourced surveys. Continue reviewing returned survey comments to identify areas for improvement.
- Q3 Patient Oriented Discharge Summaries started in late November. Would not have anticipated an improvement at this point.
- Q4 Continue to educate staff about the importance of patient education and perform regular audits.

Indicator: Readmission Rate for (QBP) COPD

Strategic Direction: Patient Inspired Care

Definition: The measuring unit of this indicator is an admission for chronic obstructive pulmonary disease (COPD), as defined by QBP. Results are expressed as the number of COPD patients (QBP cohort) readmitted with same or related diagnosis within 28-days of discharge. **Denominator includes total number of COPD indexed discharges from hospital with the exclusion of records where patient had an acute transfer out, or where discharge disposition is sign out or death.** Overall QBP criteria includes; most responsible diagnosis of COPD, Ontario resident, valid Health Care Number, and Age >=35. Readmissions include non-elective admissions.

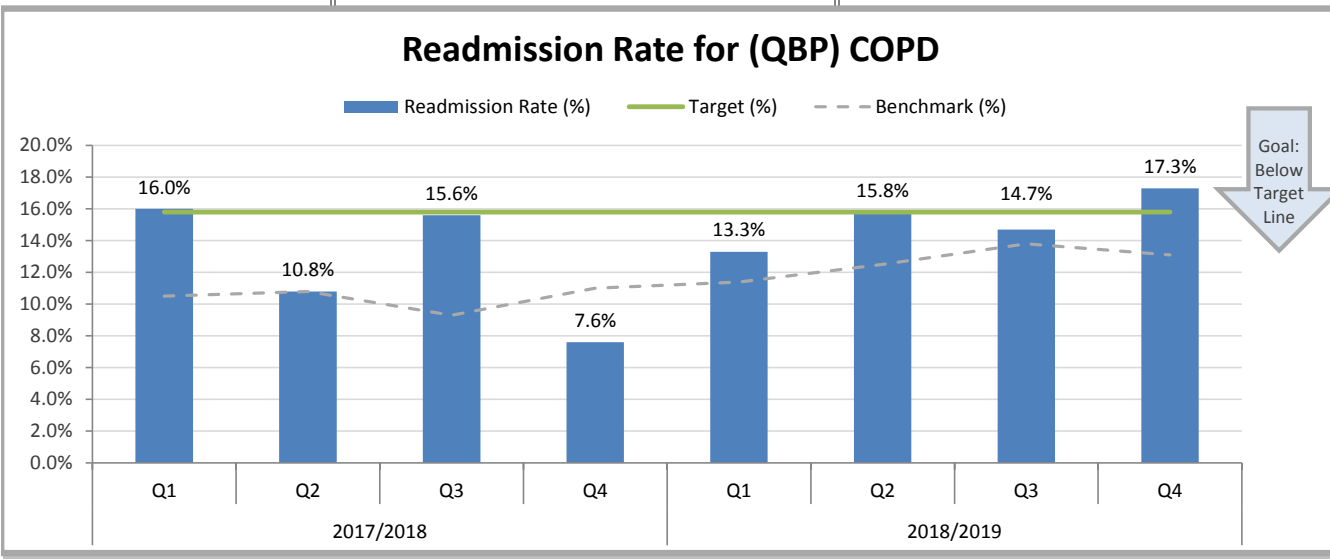
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it, this can help to reduce the number of preventable hospital readmissions. (MOHLTC - Excellent Care for All Act (2010).

Data Source: DAD (Discharge Abstract Database)

Target Information: Target is set internally at 15.8 in accordance to QIP indicator

Benchmark Information: Benchmark performance is based on our Peer Benchmark Hospitals quarterly performance

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	16.0%	10.8%	15.6%	7.6%	13.3%	15.8%	14.7%	17.3%
Benchmark (%)	10.5%	10.8%	9.3%	11.0%	11.4%	12.5%	13.8%	13.1%
Target (%)	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%	15.8%



Performance Analysis:

- Q1** There was a total of 22 readmissions out of 114 QBP COPD visits. Of the 22 readmissions, 9 readmissions were related to a single patient. When removing this atypical patient (outlier), the rate reduces to 12.4% which brings us below the expected target.
- Q2** Rates have increased slightly from Q1. Meeting expected target of 15.8%. Plans in progress to continue reduction below target.
- Q3** Target continues to be met.
- Q4** Slightly above target. In comparison to Q3, there were 110 total indexed patients in Q4 as opposed to 75 in Q3; this calculates to a 47% increase of indexed patients from Q3 to Q4. This number may be influenced by new coding processes. Overall, FY1819 annual readmission rate is within target at 14.6%.

Plans for Improvement:

- Q1** Further awareness regarding COPD order sets required. Collaboration with Seaway Valley Community Health Centre (SVCHC) is ongoing. A Nurse Practitioner from the Respiratory Clinic consults with inpatients who have COPD and provides health promotion strategies for their transition to the community. The physicians are encouraged to utilize the power plans that have the necessary referrals built into them.
- Q2** The majority of staff have now been trained in with the concept and logistics of Patient Oriented Discharge Summaries (PODS) and discharge folders are being ordered for patients. Work continues with SVCHC. Hospitalists and the CI Team are working to improve uptake of COPD order sets.
- Q3** Work continues with hospitalists to "drill down" on discussions related to the use of power plans.
- Q4** Work continues as above. Exploration of strategies to support patients discharged with COPD will occur in collaboration with SVCHC. A COPD Telehome Monitoring strategy (in collaboration with TOH) will be explored for the Outpatient Respiratory Clinic.

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Indicator: Complaints Acknowledged

Strategic Direction: Patient Inspired Care

Definition: The percentage of complaints acknowledged to the individual who made a complaint within three (3) to five (5) business days divided by the total number of complaints received in the reporting period.

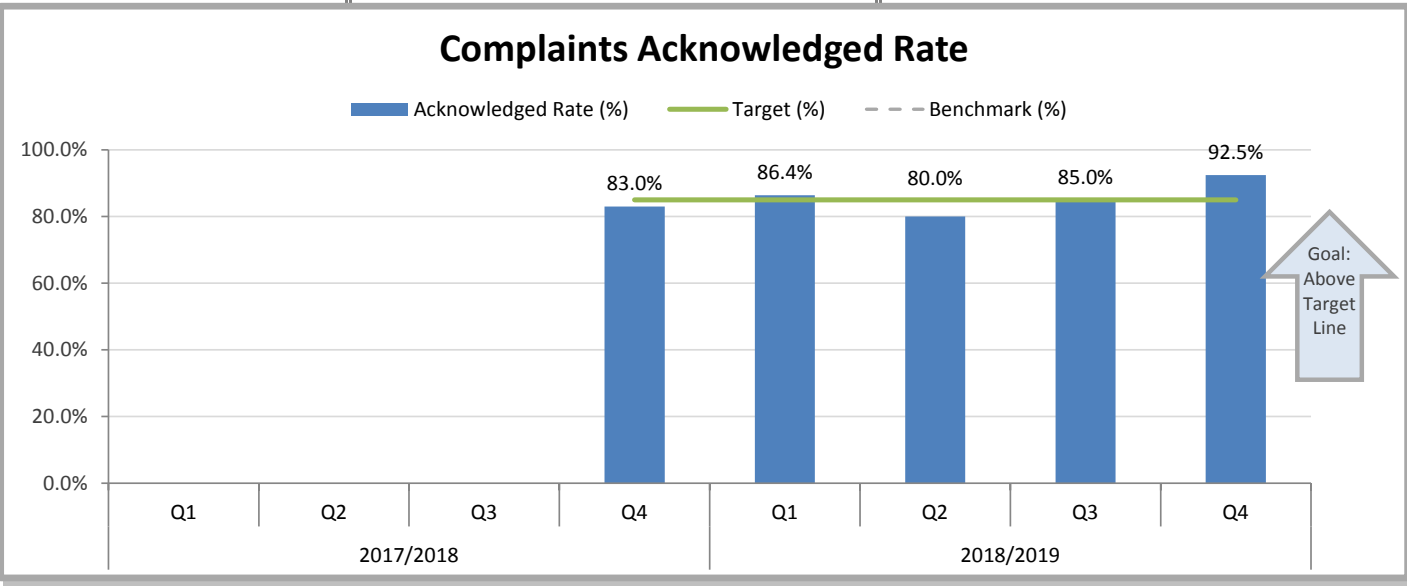
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within five business days. Complaints received by the facility need to be formally acknowledged to the individual who made the complaint.

Data Source: RL Solutions

Target Information: Target is set internally at 85.0% in accordance to QIP indicator

Benchmark Information: N/A

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)				83.0%	86.4%	80.0%	85.0%	92.5%
Benchmark (%)								
Target (%)				85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

- Q1** Continue to work with managers and Medical Staff organize to make this a priority.
- Q2** Below target. The number of complaints increased from 44 in Q1 to 60 in Q2.
- Q3** Target met.
- Q4** Target met.

Plans for Improvement:

- Q1** No plan required.
- Q2** Increased emphasis on individual accountability and work with the medical staff office to ensure process aligns with policy.
- Q3** Continued focus on maintaining performance to acknowledge complaints.
- Q4** Need to sustain results.

Accountable: VP Patient Services and Chief Nursing Officer

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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 - 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).

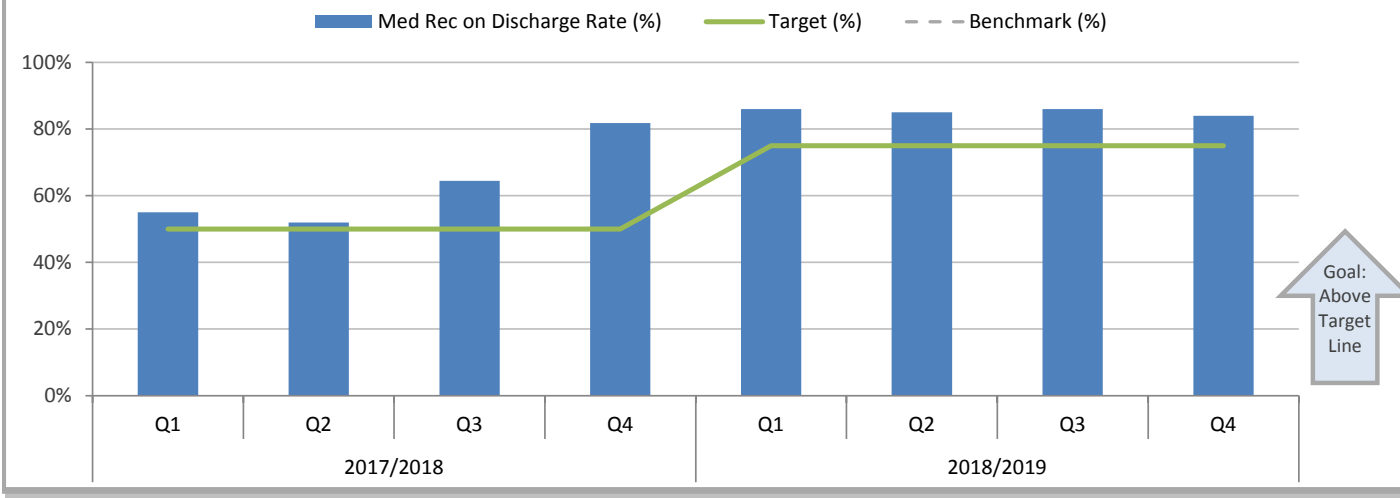
Data Source: Cerner electronic health record

Target Information: Set internally at 75% in accordance to QIP indicator

Benchmark Information: N/A

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	55%	52%	65%	82%	86%	85%	86%	84%
Benchmark (%)								
Target (%)	50%	50%	50%	50%	75%	75%	75%	75%

Medication Reconciliation on Discharge



Performance Analysis:

- Q1** The data continues to trend upward and within target.
- Q2** Target met.
- Q3** Target met.
- Q4** Target met.

Plans for Improvement:

- Q1** Continue to create awareness with various physician groups. An alert mechanism is in place to remind physicians of the necessity of completing medication reconciliation at the time of admission.
- Q2** Continue awareness to physician groups as above.
- Q3** Continue focus as Med Rec is also a required accreditation organizational practice.
- Q4** Need to sustain process that is in place.

Accountable: VP Patient Services and Chief Nursing Officer / Chief of Staff

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Indicator: Indigenous Cultural Awareness

Strategic Direction: Our Team Our Strength

Definition: The percentage of staff and physicians who participated in Indigenous training over the total number of staff and physicians. Performance is cumulative year-to-date.

Significance: As part of our strategic Plan for 2016-2021, it identifies that CCH will partner with experts and our peers to foster a climate of culture competency. We will increase access to training with a focus on frontline staff, create a policy on smudging and plan to do at least one smudging ceremony, offer sessions that are more available to front line staff, and make reports available to managers and Chief of staff with number of participants.

Data Source: LMS (Learning Management System)

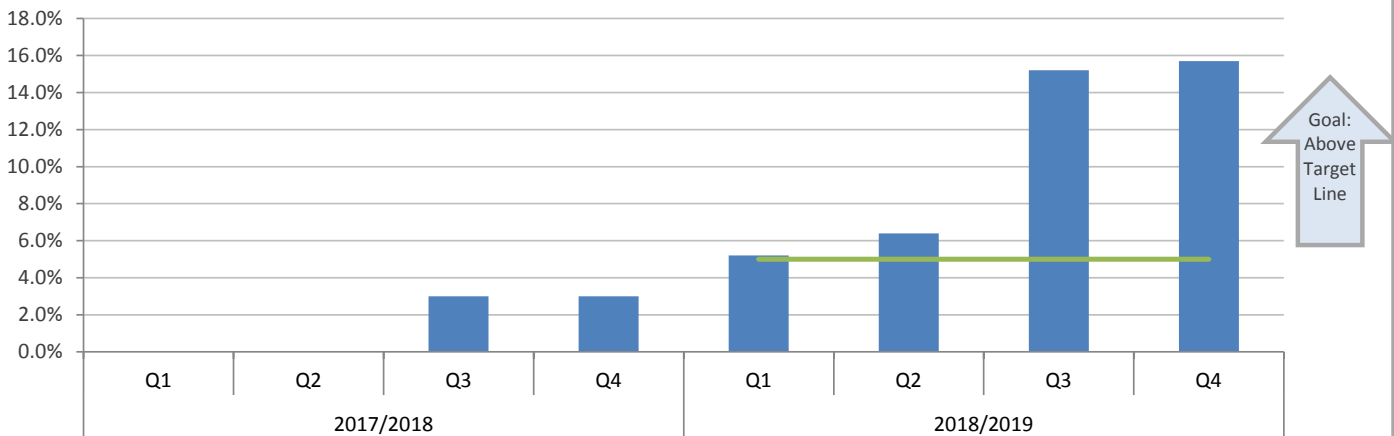
Target Information: Target is set internally at 5.0% in accordance to QIP indicator

Benchmark Information: N/A

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cultural Awareness Rate (%)			3.0%	3.0%	5.2%	6.4%	15.2%	15.7%
Benchmark (%)								
Target (%)					5.0%	5.0%	5.0%	5.0%

Indigenous Cultural Awareness Rate

■ Cultural Awareness Rate (%)
 — Target (%)
 - - - Benchmark (%)



Performance Analysis:

- Q1** Meeting target for Q1.
- Q2** Target met.
- Q3** Target met.
- Q4** Target met.

Plans for Improvement:

- Q1** Additional training planned for September.
- Q2** Training date planned November 26th.
- Q3** Continue planned training.
- Q4** Continue as above.

Accountable: VP Patient Services and Chief Nursing Officer

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Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: Our Team Our Strength

Definition: 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. Results are cumulative year-to-date.

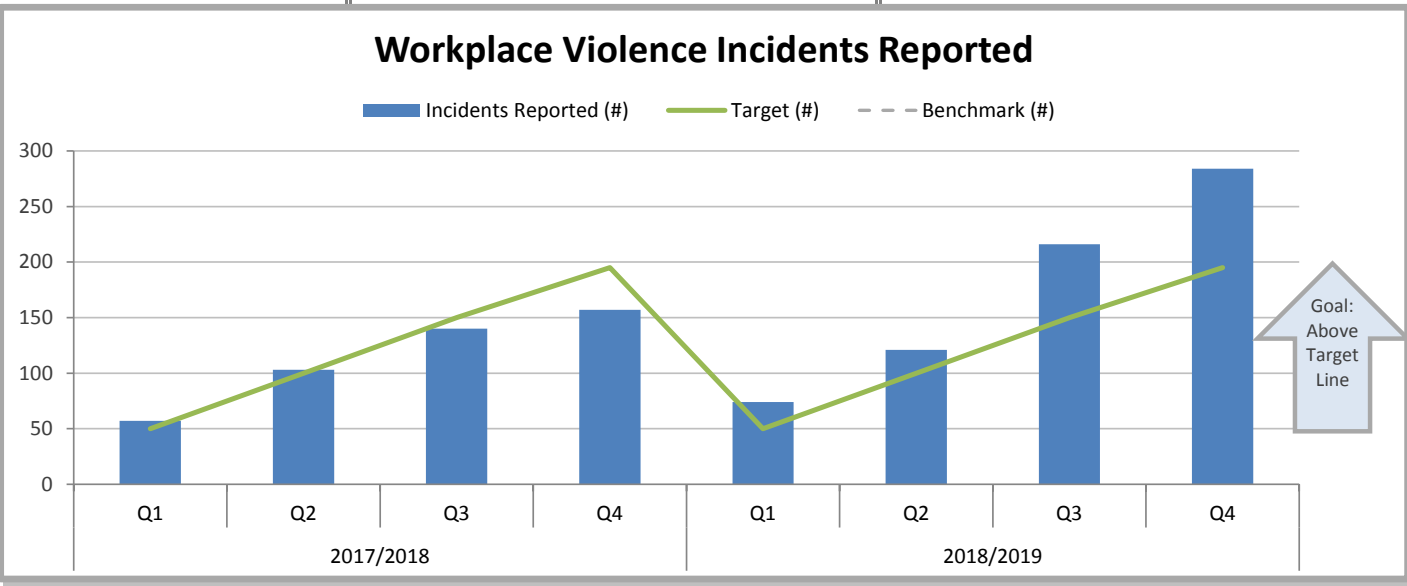
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like 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 cumulative and set internally at 50 per quarter (total of 195 annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2017/2018				2018/2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	57	103	140	157	74	121	216	284
Benchmark (#)								
Target (#)	50	100	150	195	50	100	150	195



Performance Analysis:

- Q1** Meeting target for Q1.
- Q2** Cumulative target met.
- Q3** Q3 target met.
- Q4** Target met.

Plans for Improvement:

- Q1** Continue communication strategies suggested to encourage staff and physicians to report threats or perceived threats as well as actual incidents.
- Q2** Encouraged incident reporting to include Security.
- Q3** Continue as above. Mandatory training is tracked through the learning management system (LMS) and all staff are aware of training requirements.
- Q4** No additional follow up required.

Accountable: VP Patient Services and Chief Nursing Officer

 <p>Cornwall Community Hospital Hôpital communautaire de Cornwall</p>	<p>MISSION: Our health care team collaborates to provide exceptional patient centered care</p>	 <p>Cornwall Community Hospital Hôpital communautaire de Cornwall</p>	<p>MISSION : Notre équipe de soins collabore en vue de dispenser des soins exceptionnels, axés sur les patients.</p>
<p>Strategic Plan 2016 - 2021</p>		<p>Orientations stratégiques 2016-2021</p>	
 <p>Partnering for Patient Safety and Quality</p> <p>Our Team Our Strength</p> <p>Operational Excellence through Innovation</p> <p>Patient Inspired Care</p> <p>Vision: EXCEPTIONAL CARE. ALWAYS.</p> <p>ICARE INTEGRITY • COMPASSION • ACCOUNTABILITY • RESPECT • ENGAGEMENT</p>		 <p>Travailler en partenariat pour la sécurité des patients et des résultats de qualité</p> <p>Notre force réside dans notre équipe</p> <p>Atteindre l'excellence opérationnelle grâce à l'innovation</p> <p>Offrir des soins centrés sur le patient</p> <p>Vision : DES SOINS EXCEPTIONNELS. TOUJOURS.</p> <p>ICARE INTÉGRITÉ • COMPASSION • RESPONSABILITÉ • RESPECT • MOBILISATION</p>	

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