



QUALITY IMPROVEMENT PLAN 2015/2016

Vision: A recognized Eastern Counties leader in the provision of exceptional health services.

Mission: With our partners, we provide, facilitate and enable safe, high quality health services and education to the communities we serve; in doing so, we are committed to providing services in both official languages and to the effective management and use of our resources.

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

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

HEALTH SYSTEM INTEGRATION					
Indicator	Reference	Q1	Q2	Q3	Q4
ALC - Percentage of ALC Days	HSAA/QIP	Y	G	R	
Readmission Rates for Selected CMG's	HSAA/QIP	G	G	G	

EXCELLENCE IN QUALITY, PATIENT SAFETY, & SERVICE DELIVERY					
Indicator	Reference	Q1	Q2	Q3	Q4
Emergency Visits - Time to Inpatient Bed	HSAA/QIP/SIA	G	G	G	
QBP - Stroke Patients Discharged on Anti-thrombotics	QIP	G	G	G	
QBP - Hip Fracture: Surgery Within 48 Hours	QIP	R	R	G	
ROP - Medication Reconciliation at Care Transitions	Accreditation/QIP	N/A	N/A	N/A	

OUTSTANDING OPERATIONAL & FINANCIAL PERFORMANCE					
Indicator	Reference	Q1	Q2	Q3	Q4

PEOPLE DEVELOPMENT / WORKPLACE OF CHOICE					
Indicator	Reference	Q1	Q2	Q3	Q4
Workplace Violence Prevention - Incidents	QIP	N/A	N/A	N/A	
Workplace Violence Prevention - Near Misses	QIP	N/A	N/A	N/A	

Results:

Metric underperforming target
Metric within 10% of target
Metric equal to or outperforming target
Data not available

R
Y
G
N/A

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
QIP - Quality Improvement Plan
SIA - Strategy in Action

Indicator: Percentage of Alternate Level of Care (ALC) Days

Strategic Direction: Health System Integration

Definition: The percentage 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/her treatment. The calculation is the total number of inpatient days designated as ALC for patients in acute beds discharged in a given time period divided by the total number of acute inpatient days in a given time period x 100.

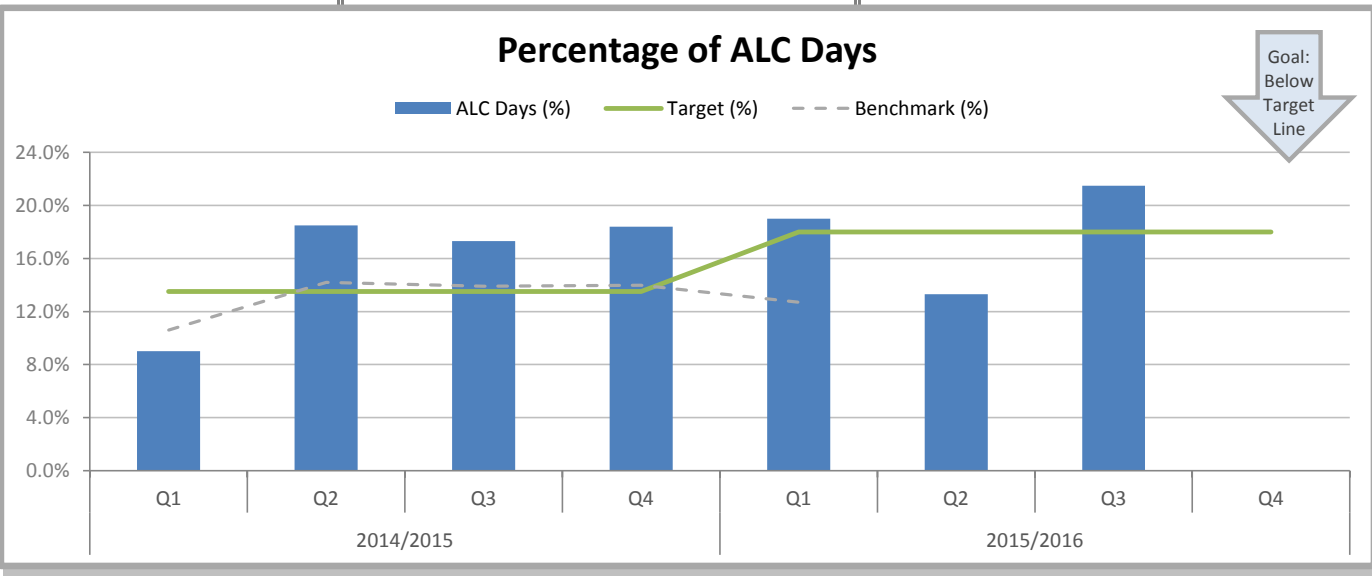
Significance: Cornwall Community Hospital will continue to identify and implement additional strategies with Champlain health care providers to reduce alternate level of care days.

Data Source: Anzer - DAD (Discharge Abstract Database).

Target Information: Target rate is set according to HSAA specifications.

Benchmark Information: Based on the average quarterly Champlain LHIN performance obtained from the Health Analytics Branch MoHLTC - Quality Improvement Plans Report.

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Days (%)	9.0%	18.5%	17.3%	18.4%	19.0%	13.3%	21.5%	
Benchmark (%)	10.6%	14.2%	13.9%	14.0%	12.7%	N/A	N/A	
Target (%)	13.5%	13.5%	13.5%	13.5%	18.0%	18.0%	18.0%	18.0%



Performance Analysis:

- Q1** Q1 shows a significant increase over the same period last year for Percentage of ALC days. CCH continues to be challenged with a lack of viable/affordable discharge options for some of our patients, especially those under 65 years of age. The significant increase in this indicator is also directly attributable to the significant increase in ALC Long Stay Cases / Patient Days that we experienced in Q1.
- Q2** Exceeded target and expectations.
- Q3** The percentage of ALC days in Q3 far exceeds the target at 21.5%. As the highest quarter in the past two fiscal years, there is a significant impact to patient flow and access to acute care services, when beds are occupied by patients no longer requiring acute hospital care.
- Q4**

Plans for Improvement:

- Q1** CCH continues to work with leadership from the Champlain LHIN, CCAC, St. Joseph's Continuing Care, as well as the Canadian Red Cross, in developing unique solutions to support the flow of ALC patients into the community and improve access to acute care.
- Q2** Continue with strategies as above. Discharging patients before they become ALC remains a priority for both the CCH and CCAC teams.
- Q3** Along with initiatives above, CCH continues to work with physicians, staff, patients and families to promote early discharge planning, identifying barriers to discharge and putting a plan in place to support return to the community before the patient becomes ALC.
- Q4**

Indicator: Readmission Rates for Selected Case Mix Groups (CMG)

Strategic Direction: Health System Integration

Definition: This indicator measures the percentage of acute hospital inpatients discharged within selected Case Mix Groups (Stroke, COPD, Pneumonia, Congestive Heart Failure, Diabetes, Cardiac CMGs, Gastrointestinal CMGs) that are readmitted for non-elective patient care within 30 days of the discharge for index admission. The original CHRP indicator, and as outlined in the HSAA, reports this rate as readmissions within 30 days. In order to facilitate timeliness and ease of reporting we will be reporting internally as readmissions within 28 days.

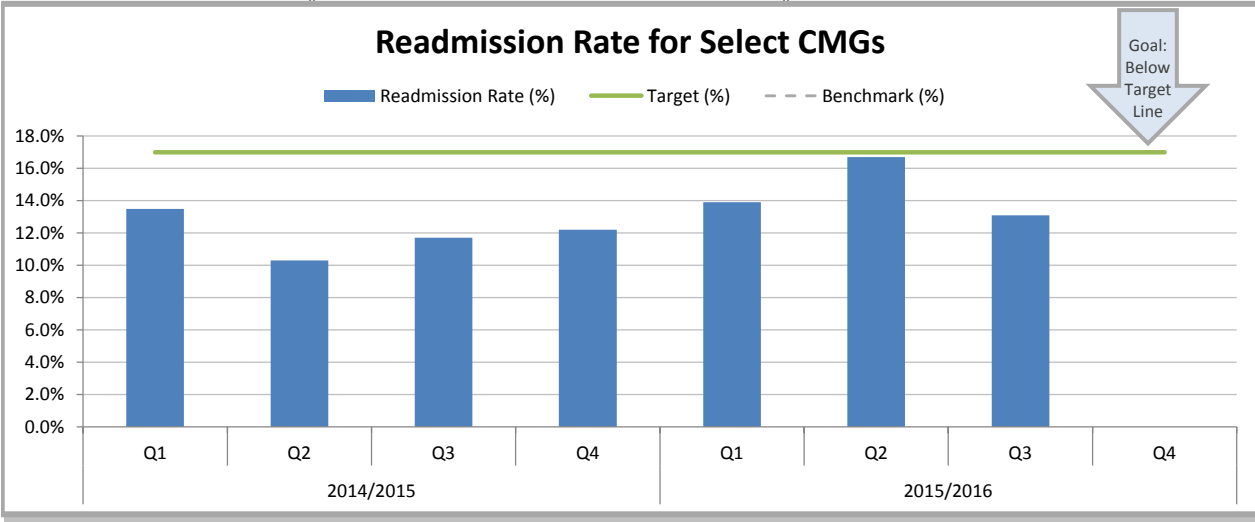
Significance: Unplanned hospital readmissions have been a focus of health service researchers and policy and decision-makers since the early 1970s. Growing attention has been given to this issue due to the burden of unplanned readmissions on patients and their family members, on the quality of health care services and on the health care system in general. Many studies have identified unplanned readmissions as common, costly and potentially avoidable (Canadian Institute for Health Information, All-Cause Readmission to Acute Care and Return to the Emergency Department (Ottawa, Ont.: CIHI, 2012)). Narrowing the scope of readmissions by focusing on specific Case Mix Groups allows the organization to more readily identify those areas that may be struggling with readmissions, therefore permitting us to focus our efforts.

Data Source: Discharge Abstract Database (DAD)

Target Information: Target rate is set according to HSAA specifications.

Benchmark Information:

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	13.5%	10.3%	11.7%	12.2%	13.9%	16.7%	13.1%	
Benchmark (%)								
Target (%)	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%



Performance Analysis:

Q1 While performance continues to meet target, the trend over the last four quarters has been an increasing rate. This quarters rate has surpassed the first quarter rate of last fiscal year. We hope to see a drop at Q2 as occurred last year.

Q2 Target met, trend continues upward. Q2 this year did not result in the decrease that occurred in the previous fiscal.

Q3 Target met, significant decrease from Q2.

Q4

Plans for Improvement:

Q1 No plans for improvement required at this time

Q2 Although we remain on target, the upward trend indicates we must continue to focus on prevention strategies which include: Health Links; Discharge planning, patient education, and follow up planning; Electronic Medical Records (FHIT); and improving communication on care plans with the previous MRP when a recently discharged patient comes back to the ER.

Q3 All the issues identified in "Readmission Rate for Admitted Patients" applies here as well. Prevention of hospital adverse events, more effective care transitions and targeting better chronic disease management and prevention for these specific CMG's is the focus.

Q4

Indicator: Emergency Visits - Time to Inpatient Bed (TIPB)

Strategic Direction: Excellence in Quality, Patient Safety, & Service Delivery

Definition: Using Pay-for-Results program indicator for admitted patients which is based on the 90th percentile ER length of stay. Time calculated from Disposition time to time patient left ED for admitted patients only.

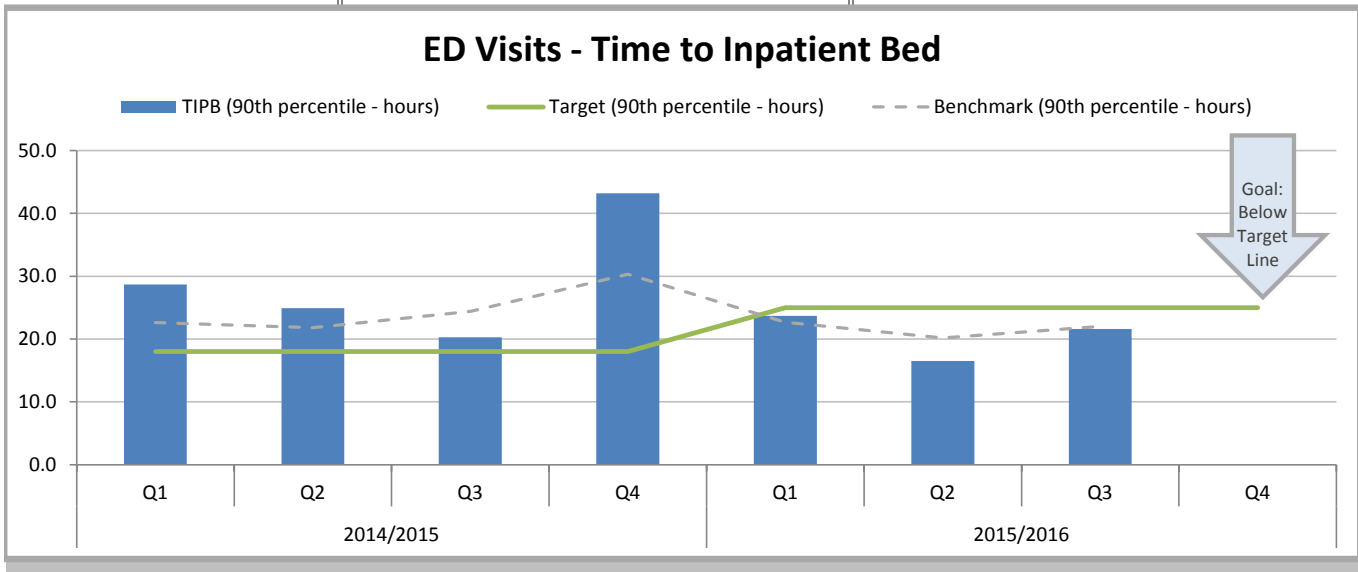
Significance: Rapid movement from the Emergency Department (ED) after a decision to admit the patient is critical for entry to the entire system for emergent patient care. It represents the ability of the system to handle unscheduled admissions (Institute for Healthcare Improvement, 2011).

Data Source: Access to Care Emergency Room Fiscal Year Report (ERNI)

Target Information: Target is set internally at 18 and based on Strategy in Action directives. Ontario's Pay for Results (P4R) target and HSAA obligation is set at 25 hours.

Benchmark Information: Based on the ATC "High-Volume Community Hospital Group"

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
TIPB (90th percentile - hours)	28.7	24.9	20.3	43.2	23.7	16.5	21.6	
Benchmark (90th percentile - hours)	22.6	21.8	24.4	30.3	22.7	20.2	22.0	
Target (90th percentile - hours)	18.0	18.0	18.0	18.0	25.0	25.0	25.0	25.0



Performance Analysis:

- Q1** TIPB outperforming target by 1.3 hours. A marked improvement over Q4 2014/15 (decreased by 19.4 hours). In comparison to 2014/15 Q1 a decrease of 5 hours was achieved.
- Q2** Marked improvement compared to Q1. Decrease occupancy and revision of policy regarding patient flow has contributed to improved performance.
- Q3** As hospital occupancy levels increase it is difficult to improve performance.
- Q4**

Plans for Improvement:

- Q1** Ongoing initiatives including predictive discharge strategies and utilizing the "pull-Model" are in place. Discharge predictability is tracked and communicated to staff during regular Huddles. Physician engagement during bi-weekly rounds and mobilization strategies to decrease functional decline are continued priorities to support patient flow and improved access to inpatient beds.
- Q2** Monitor access to in-patient beds, continue with current strategies.
- Q3** Continued focus as a Strategy in Action.
- Q4**

Indicator: QBP - Stroke Patients Discharged on Antithrombotics

Strategic Direction: Excellence in Quality, Patient Safety, & Service Delivery

Definition: The percentage of QBP Stroke (ischemic) patients discharged from acute care who were prescribed antithrombotic therapy on discharge.

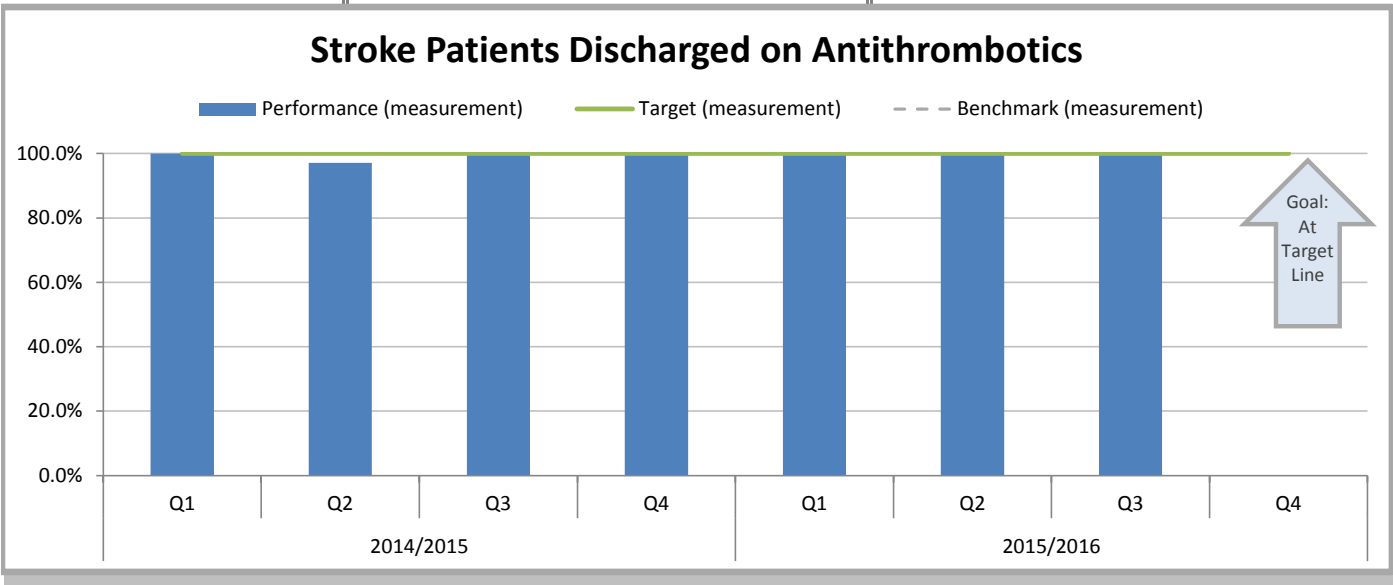
Significance: This is an indicator of appropriate prevention strategies to mitigate the risk of another vascular event or death. All (appropriate) stroke/TIA patients should be discharged on antithrombotics (MOHLTC Quality-Based Procedures: Clinical Handbook for Stroke, pg. 53)

Data Source: Discharge Abstract Database (DAD)

Target Information: Target set based on QIP; theoretical best

Benchmark Information:

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Performance (measurement)	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%	100.0%	
Benchmark (measurement)								
Target (measurement)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%



Performance Analysis:

- Q1** Target met. Performance adjusted since chart review performed. There was one case contributing to the decreased rate in Q2 of last year. This case has been reviewed.
- Q2** Performance continues to meet target.
- Q3** Performance continues to meet target.
- Q4**

Plans for Improvement:

- Q1** This measure has typically been met in the past, which indicates there may be a coding issue for some stroke patients. An audit of 10 stroke patients charts who did not receive prescribed antithrombotic therapy on discharge will be conducted in Sept to determine if this is the case.
- Q2** No plan required.
- Q3** No plan required.
- Q4**

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Indicator: QBP - Hip Fracture: Percentage of Patients who Underwent Surgery within 48 Hours

Strategic Direction: Excellence in Quality, Patient Safety, & Service Delivery

Definition: This indicator measure the percentage of (QBP) hip fracture patients, 18 years and older, admitted to hospital that received hip fracture surgery within 48 hours of their initial presentation. (MOHLTC - QBP Baseline Results report May 2015)

Calculation: QBP hip fracture patients receiving surgery within 48 hours divided by total QBP hip fracture patients receiving surgery.

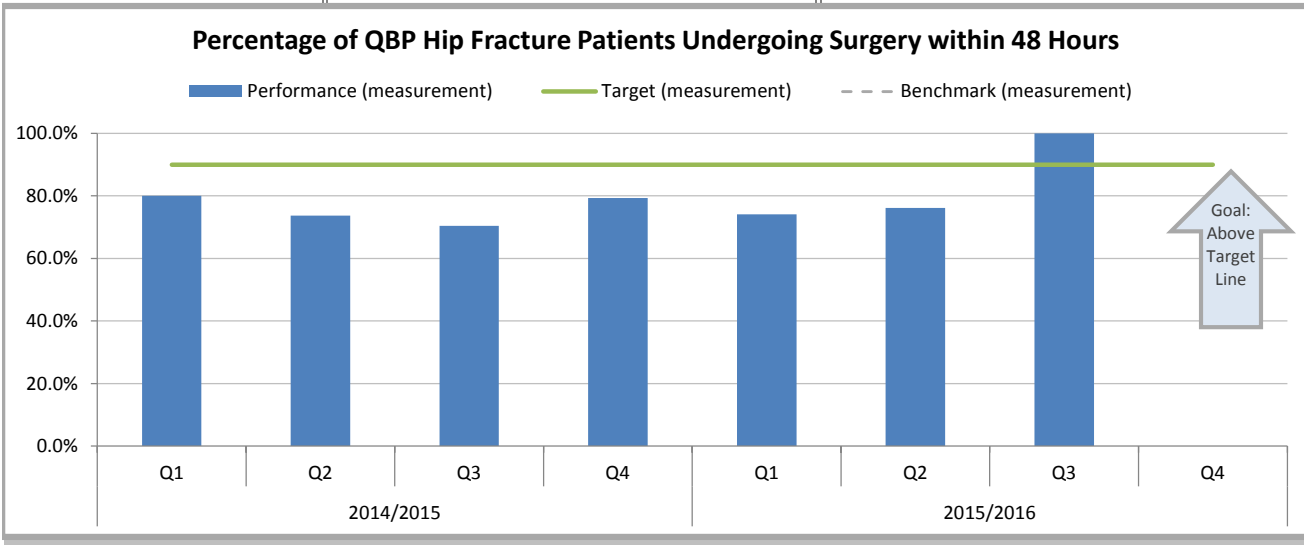
Significance: Hip fracture surgery should be performed as early as possible. The hip fracture QBP clinical expert panel recommend that patients undergo surgery within 48 hours. Some studies have also shown that shorter wait time to surgery is associated with decreased risk of morbidity, mortality, and other postoperative complications (Bone and Joint Canada, 2011). (MOHLTC - QBP Baseline Results report May 2015)

Data Source: Discharge Abstract Database (DAD)

Target Information: The clinical expert panel recommended from a clinical perspective that hospitals should strive to have 90% of their hip fracture patients undergo surgery within the specified timeframe. (MOHLTC - QBP Baseline Results report May 2015)

Benchmark Information:

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Performance (measurement)	80.0%	73.7%	70.4%	79.3%	74.1%	76.2%	100.0%	
Benchmark (measurement)								
Target (measurement)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Year-to-date performance for 2014/15 fiscal year was 76.0%. Current performance is 1.9 percentage points below that. Given that last fiscal saw the first quarter as the highest performer, we are hoping to see significant gains over the coming months. Delays occur when patients are not ready for surgery, for example, anticoagulants need to be stopped anywhere from 3-7 days prior to the surgery.

Q2 Below provincial target. Five patients did not access the OR within the 48 hour timeframe for Q2. Chart review completed and all 5 patients were on oral anticoagulants, hence delayed access to the OR. Had these cases been excluded performance would be at 100%.

Q3 Performance exceeding target.

Q4

Plans for Improvement:

Q1 Work with the anesthetists to develop a process to optimize patient readiness for surgery. Every effort is made to ensure fractured hip patients have quick access to the OR.

Q2 Continue with plan above. Chart review of all fractured hip patients to determine delay in accessing Operating Room.

Q3 Continue with current strategies.

Q4

Indicator: Accreditation Canada Required Organizational Practice (ROP) - Medication Reconciliation at Care Transitions

Strategic Direction: Excellence in Quality, Patient Safety, & Service Delivery

Definition: 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). This indicator will report specifically on medication reconciliation at care transitions; even more specifically those transfers out of the Critical Care Unit. The goal of medication reconciliation at internal transfer is to compare the medication the client was receiving on the transferring/sending unit with those that were being taken at home to determine if any medications need to be continued, restarted, discontinued, or modified (Accreditation Canada ROP Guide).
 Calculation: # CCU patients transferred out with completed Med Rec divided by the total # of CCU patients transferred out. This calculation excludes discharges home from the unit.

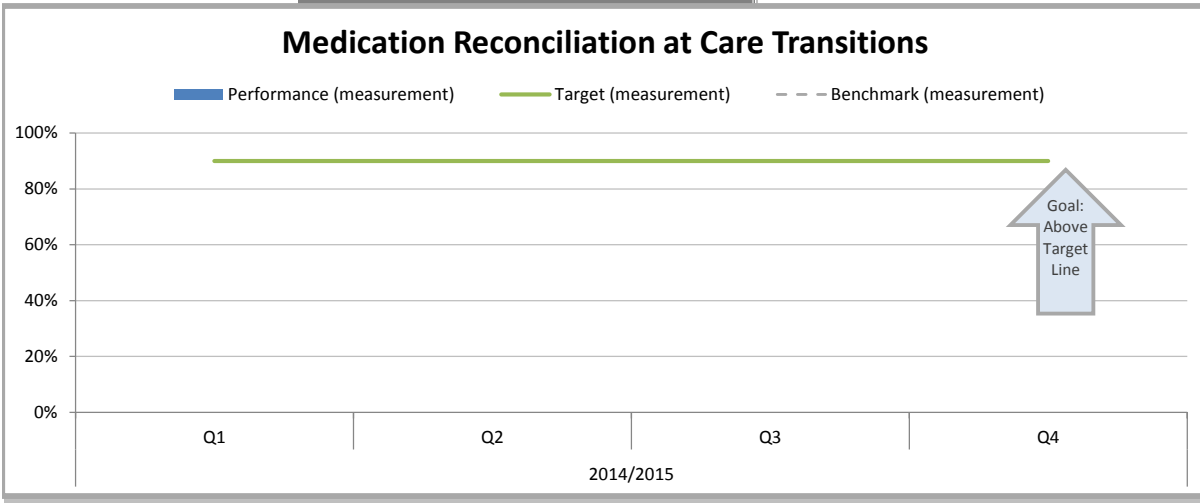
Significance: It is well known that adverse drug events (ADEs) occur with disturbing frequency, and that communication problems between settings of care are a significant factor in their occurrence. In the Canadian Adverse Events Study, drug and fluid related events were the second most common type of procedure or event to which adverse events were related. Moreover, chart reviews have revealed that over half of all hospital medication errors occur at the interfaces of care. At Care Transfer: In a 2010 Canadian study, 62.0% of the study population had at least 1 unintentional medication discrepancy at the time of transfer, and the most common discrepancy was medication omission (55.6%). Factors that independently increased the risk of a patient experiencing at least 1 unintentional discrepancy included lack of best possible medication history, increasing number of home medications, and increasing number of transfer medications. Forty-seven patients (36.4%) had at least 1 unintentional discrepancy with the potential to cause discomfort and/or clinical deterioration. (Safer Healthcare Now! Medication Reconciliation in Acute Care Toolkit, Sept 2011).

Data Source: Internal audit and tracking

Target Information: Set internally

Benchmark Information: Not available at this point

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Performance (measurement)	N/A				N/A	N/A	N/A	
Benchmark (measurement)								
Target (measurement)					90%	90%	90%	90%



Performance Analysis:

- Q1** Performance will begin being captured mid-September. To allow for improved data quality we will report on this indicator at Q3 (October - December).
- Q2**
- Q3** Preliminary data obtained, required for accreditation, indicated compliance. Compliance over period being monitored was 98%.
- Q4**

Plans for Improvement:

- Q1**
- Q2**
- Q3** Recommend not continuing as it is very labour intensive to acquire the data.
- Q4**

Indicator: Workplace Violence - Volume of Incidents

Strategic Direction: People Development / Workplace of Choice

Definition: Workplace Violence is defined 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; an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or, a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

This indicator will report on the number of workplace violence incidents where actual physical contact occurred (regardless of whether or not this contact causes harm), in each quarter.

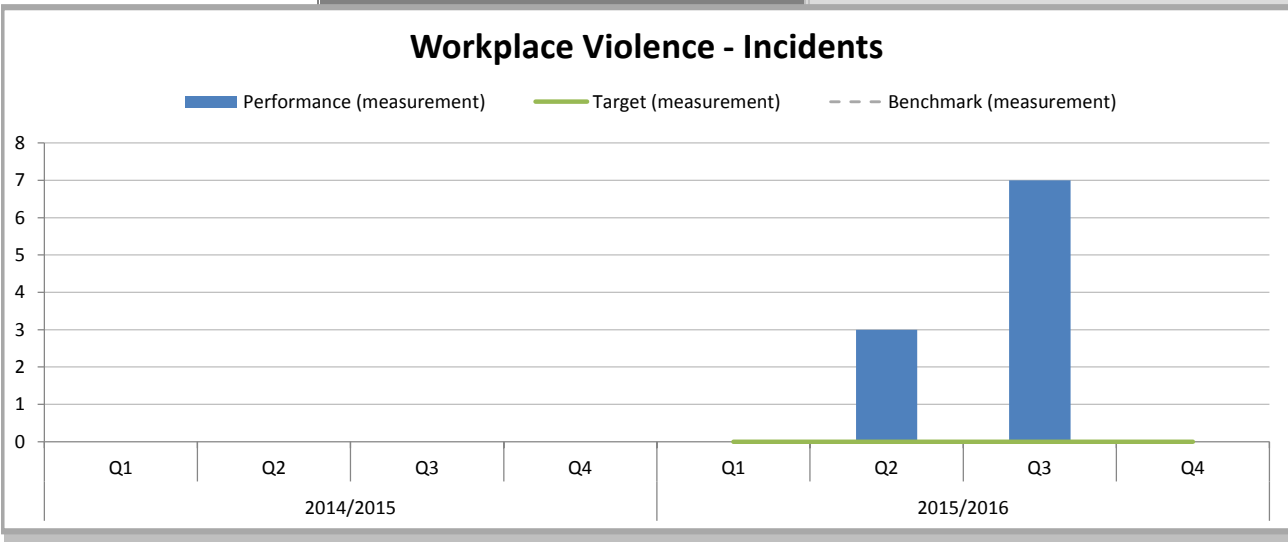
Significance: Workplace violence is very common in health care settings, more so than in many other workplaces. One-quarter of all incidents of workplace violence occur at health services organizations. Furthermore, workplace violence is an issue that affects staff and health providers across the health care continuum (Accreditation Canada - Workplace Violence Prevention ROP Workbook). CCH is committed to providing a safe workplace for all of its employees. Through the monitoring of Workplace Violence Incidents and Near Misses we will be able to develop concrete action plans that will allow us to respond to the growing concern about violence in health care workplaces.

Data Source: RL Solutions - Incident Reporting

Target Information:

Benchmark Information:

	2014/2015				2015/2016						
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			
Performance (measurement)	N/A				N/A	3	7				
Benchmark (measurement)					N/A						
Target (measurement)					N/A	N/A	N/A	N/A			



Performance Analysis:

- Q1** In order to ensure quality data we will defer reporting on this indicator at Q1. Data capture is being reviewed; education has been provided regarding the process of reporting these incidents as well as what should be reported. Performance will be reported at Q2.
- Q2** Three incidents were captured in Q2. We will continue regular monitoring and data collection. Once sufficient historical data is available a target will be developed based on internal performance.
- Q3** Seven incidents in Q3.
- Q4**

Plans for Improvement:

- Q1** N/A until more data is captured
- Q2** The Senior Team working group continues progressing the prevention agenda, focusing on security guards contracts, seclusion room upgrades, staff training enhancements, and working with external partners.
- Q3** Continue to regularly monitor and collect data.
- Q4**

Indicator: Workplace Violence - Volume of Near Misses

Strategic Direction: People Development / Workplace of Choice

Definition: Workplace Violence is defined 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; an attempt to exercise physical force against a worker, in a workplace, that could cause physical injury to the worker; or, a statement or behaviour that it is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

This indicator will report on the number of workplace violence near misses (these include the threat or attempt to harm without actual physical contact), occurring in each quarter.

Significance: Workplace violence is very common in health care settings, more so than in many other workplaces. One-quarter of all incidents of workplace violence occur at health services organizations. Furthermore, workplace violence is an issue that affects staff and health providers across the health care continuum (Accreditation Canada - Workplace Violence Prevention ROP Workbook). CCH is committed to providing a safe workplace for all of its employees. Through the monitoring of Workplace Violence Incidents and Near Misses we will be able to develop concrete action plans that will allow us to respond to the growing concern about violence in health care workplaces.

Data Source: RL Solutions - Incident Reporting

Target Information:

Benchmark Information:

	2014/2015				2015/2016			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Performance (measurement)	N/A				N/A	9	6	
Benchmark (measurement)								
Target (measurement)					N/A	N/A	N/A	N/A



Performance Analysis:

- Q1** In order to ensure quality data we will defer reporting on this indicator at Q1. Data capture is being reviewed; education has been provided regarding the process of reporting these incidents as well as what should be reported. Performance will be reported at Q2.
- Q2** Nine incidents were captured in Q2. We will continue regular monitoring and data collection. Once sufficient historical data is available a target will be developed based on internal performance.
- Q3** Six incidents in Q3.
- Q4**

Plans for Improvement:

- Q1** N/A until more data is captured
- Q2** The Senior Team working group continues progressing the prevention agenda, focusing on security guards contracts, seclusion room upgrades, staff training enhancements, and working with external partners.
- Q3** Continue to monitor and collect data.
- Q4**



1 HEALTH SYSTEM INTEGRATION

Lead efforts to establish formal linkages and pathways among providers in order to drive quality and play a leading role in health system integration.

INTÉGRATION DU SYSTÈME DE SANTÉ

Mener les efforts pour établir des voies d'accès et des liens formels entre les fournisseurs afin de favoriser la qualité, puis jouer un rôle de chef de file dans l'intégration du système de santé.



2 EXCELLENCE IN QUALITY, PATIENT SAFETY AND SERVICE DELIVERY

CCH will embed and integrate quality into its organizational culture as this focus on quality will enable the drive towards clinical and operational excellence.

EXCELLENCE DANS LA QUALITÉ ET LA PRESTATION DE SERVICES

L'HCC implantera et intégrera la qualité dans sa culture organisationnelle, car cette orientation sur la qualité lui donnera l'élan vers l'atteinte de l'excellence dans la prestation de ses services médicaux et de son fonctionnement.



3 OUTSTANDING OPERATIONAL & FINANCIAL PERFORMANCE

Support the continued improvement in operational and financial performance through accountability structures, staff training and resources.

RENDEMENT OPÉRATIONNEL ET FINANCIER EXCEPTIONNEL

Soutenir l'amélioration continue du rendement opérationnel et financier par la mise en place de structures de responsabilité, par la formation du personnel et par les ressources.



4 PEOPLE DEVELOPMENT/WORKPLACE OF CHOICE

Engage and empower our people to lead and drive internal organizational and health system transformation.

PERFECTIONNEMENT DU PERSONNEL/MILIEU DE TRAVAIL DE CHOIX

Susciter l'intérêt du personnel et l'habiliter à mener la transformation organisationnelle interne et du système de santé dans son ensemble.