Excellent Care For All.

2013/14

Quality Improvement Plan for Ontario Hospitals

(Short Form)

Cornwall Community Hospital
Hôpital communautaire de Cornwall

March 7, 2013

This document is intended to provide public hospitals with guidance as to how they can satisfy the requirements related to quality improvement plans in the *Excellent Care for All Act, 2010* (ECFAA). While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and hospitals should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, hospitals are free to design their own public quality improvement plans using alternative formats and contents, provided that they comply with the relevant requirements in ECFAA, and provided that they submit a version of their quality improvement plan to HQO in the format described herein.

Overview of Our Organization's Quality Improvement Plan

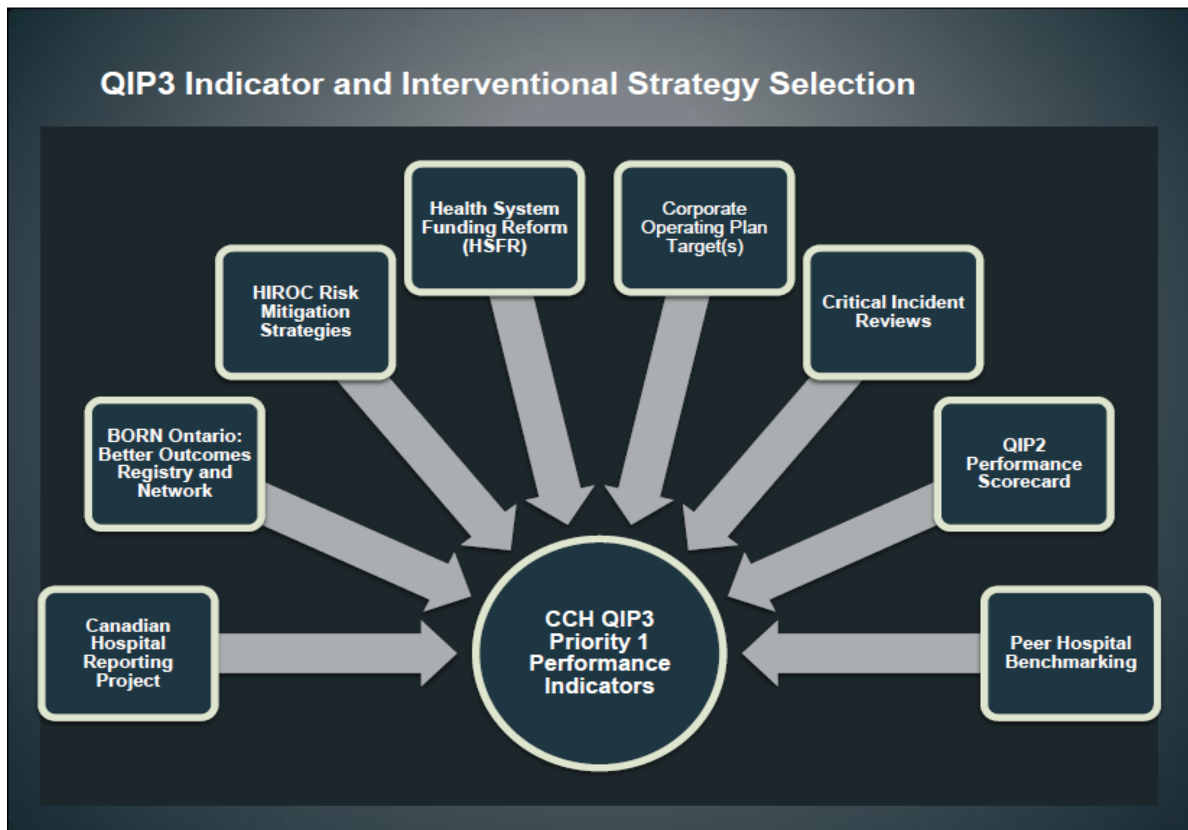
Overview: Provide a brief overview of your organization's QIP.

- For the FY 2013/2014, a total of seven (7) indicators have been designated as priority one (1):
    1. NRC Picker/ HCAPHS: "Would you recommend this hospital to your friends and family?"
    2. NRC Picker: "Overall, how would you rate the care and services you received at the hospital?"
    3. Canadian Hospital Reporting Project: Caesarean Section Rate (rate per 100).
    4. Canadian Hospital Reporting Project: Obstetric Trauma - Vaginal Delivery With Instrument (rate per 100).
    5. BORN Ontario: Rate of episiotomy or $3^{rd}/4^{th}$ perineal laceration among women who had a vaginal birth.
    6. Hand hygiene compliance before patient contact.
    7. Rate of in-hospital mortality following major surgery.

Focus: Describe the objectives of your organization's QIP and how they will improve the quality of services and care in your organization.

- Selected priority one indicators within the CCH QIP3 emphasizes patient safety, quality of care and establishing the necessary infrastructure, safeguards and evidence-based, best practices to produce the best possible outcomes for the patient populations served, i.e., the objective of three (3) of the seven (7) priority 1 indicators minimize preventable obstetrical injury.

Alignment: Describe how your plan aligns with other planning processes in your organization (e.g., H-SAA, Accreditation Canada, etc.).



Integration and continuity of care: Describe how your plan takes into consideration integration and continuity of care of patient across sectors.

- It is anticipated that NRC Picker priority indicators (2) results will act as proxy for effectiveness of integration and continuity of care performance.

Health System Funding reform (HSFR): Describe how your organization is incorporating HSFR into your larger quality processes, including the QIP. Refer to Appendix D of the 2013/14 QIP Guidance Document for Ontario Hospitals for more information on HSFR.

- CCH selected priority indicators link to Health System Funding Reform (HSFR) which aims to: Be transparent and evidence-based to better reflect population needs; Support quality improvement; Support system service capacity planning; Encourage provider adoption of best practice through linking funding to activity and patient outcomes; and, Ensure Ontarians will get the right care, at the right place and at the right time.
- Canadian Hospital Reporting Project (CHRP) National Quartile Performance (FY 2011/12) placed both CCH's Primary Caesarean Section Rate (rate per 100) and Caesarean Section Rate (rate per 100) within the 4th quartile. Further analysis of both indicators against 18 Ontario peer hospitals demonstrated significant increase in conservable bed days[1] and direct cost savings if peer median and best quartile performance was achieved, in addition to the benefits accrued to the patients served.
- Likewise Hand Hygiene was selected as a priority 1 initiative, recognizing, not only as a significant safety opportunity to reduce avoidable patient morbidity and mortality due to hospital-acquired infections (HAIs), but also effective prevention of transmission by health care providers would translate into a significant increase in conservable bed days, i.e., additional lengths of stay due to an HAI, and direct cost savings associated with an extended hospitalization or rehospitalization.

Challenges and risks: Describe any *challenges and risks* that your hospital has identified in the development of the QIP.

- About 1 in 6 Eastern Counties' residents (14.9%) are 65 years or older compared with 1 in 8 (12.4%) in Ottawa (2006).
- Eastern Counties' residents are six times more likely to live in a rural1 setting (48.5%vs. 8.3% in Ottawa, 2006).
- Eastern Counties' residents are more than twice as likely to have French as a mother tongue (42.0% vs. 16.1% in Ottawa, 2006).
- Including Akwesasne, the proportion of Eastern Counties' residents who are Aboriginal is 6.5% compared with 1.5% in Ottawa (2006).
- Over the next 20 years, the number of seniors (65+) in Eastern Counties is projected to approximately double.^^ The population under 65, meanwhile, is actually projected to decline by about 4%. There is now 1 senior for every 5 people under 65; whereas in 20 years, the ratio will be 1 to 3.
- Eastern Counties' residents have, on average, less education but are less likely to be classified as 'low income' than people in Ottawa.
- Smoking, second hand smoke exposure and obesity are more prevalent in Eastern Counties than in Ottawa.
- Life expectancy is lower in Eastern Counties than Ottawa. Some of the difference is explained by higher rates of mortality from circulatory disease, respiratory disease and lung cancer.
- The mortality from circulatory diseases (including coronary artery disease and stroke) about one-third higher among Eastern Counties' residents compared with Ottawa (247.6 vs. 186.5 per 100,000, 2000 to 2002).
- For respiratory disease mortality, the rate is 20% higher and for lung cancer, it is 30% higher.
- Compared with Ottawa, Eastern Counties' residents rate their health worse, are more likely to report pain or discomfort, and may have more activity limitations due to health conditions.

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[1] **Conservable Bed Days: The number of days that might be conserved if a hospital decreased the adjusted average length of stay (LOS) from existing levels to the benchmark levels (ICES).**

- More than one-third (35.0%) of Eastern Counties' residents, aged 12 and older, report that limitations in activities because of a chronic physical or mental health condition or problem.
- Eastern Counties' residents are twice as likely to report that they usually experience moderate or severe pain (20.3% vs. 10.4% in Ottawa, 12+, 2008).
- Eastern Counties' residents are more likely to rate their health as 'poor' or 'fair' than those living in Ottawa (16.9% vs. 9.5%, 12+, 2008).

See Clinical Services Planning: Eastern Counties (Champlain LHIN).

Link to performance-based compensation: As a mandatory component of ECFAA, describe the manner in and extent to which compensation of your organization's executives is tied to achievement of the targets in your QIP (refer to the 2013/14 QIP Guidance Document for Ontario Hospitals for more information on completing this section)].

- 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 BPSAA, executives within our organization do not have any pay-for-performance tied to the achievement of targets in our 2013/14 QIP.

Accountability Sign-off

I have reviewed and approved our organization's Quality Improvement Plan and attest that our organization fulfills the requirements of the Excellent Care for All Act.

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Helene Periard **Board Chair**	**Naresh Bhargava** **Quality and Performance Monitoring Committee Chair**	**Jeanette Despatie** **Chief Executive Officer**

Our Improvement Targets and Initiatives

Cornwall Community Hospital Quality Improvement Plan 3.0 2013/14

AIM		MEASURE					CHANGE			
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for Change Ideas (2013/14)	Comments
Access	Reduce wait times in the ED	**ER Wait times**: 90th Percentile ER length of stay for Admitted patients. Q4 2011/12 - Q3 2012/13, iPort	34.1%	30.5%	Q4 2011/12 - Q3 2012/13 Peer = 29.9% LHIN = 30.5%	2				
Effectiveness	Improve organizational financial health	**Total Margin (consolidated)**: Percent, by which total corporate (consolidated) revenues exceed or fall short of total corporate (consolidated) expense, excluding the impact of facility amortization, in a given year.	Q3, 2012/13 = 0.017%	0%	HSAA/LHIN Agreement = 0%	2				
	Reduce unnecessary deaths in hospitals	**HSMR**: Number of observed deaths/number of expected deaths x 100 - FY 2011/12, as of December 2012, CIHI	79	75 (Reduce by 5%)	CIHI HSMR Report FY2011/12 Champlain LHIN = 92	2				
Integrated	Reduce unnecessary time spent in acute care	**Percentage ALC days**: Total number of inpatient days designated as ALC, divided by the total number of inpatient days. Q3 2011/12 – Q2 2012/13, DAD, CIHI	17.8%	16.25% (Reduce by 5%)	FY2011/12 Champlain LHIN = 14.62%	2				
	Reduce unnecessary hospital readmission	**Readmission within 30 days for selected CMGs to any facility**: The number of patients with select CMGs readmitted to any facility for non-elective inpatient care within 30 days of discharge, compared to the number of expected non-elective readmissions - Q2 2011/12 – Q1 2012/13, DAD, CIHI	11.3%	10.74% (Reduce by 5%)	FY2011/12 Champlain LHIN = 15.08%	2				

AIM		MEASURE					CHANGE			
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for Change Ideas (2013/14)	Comments
Patient-Centred	Improve patient satisfaction	**From NRC Picker/ HCAPHS**: "Would you recommend this hospital to your friends and family?" (add together percent of those who responded "Definitely Yes" or "Yes, definitely") Q3 2011/12 – Q2 2012/13	ER = 58.0% IP = 62.77%	ER = 70.6% IP = 81.8%	80th percentile of 2010/2011 NRC Picker Canada Ontario hospital data.	1	1. Continue quarterly analysis of NRC Picker to assess patients' perceptions of care and CCH's patient-centredness: analyze corporate and department-specific themes and action opportunities within identified performance shortfalls. 2. Analyze and action opportunities to improve: patient flow in the ER; communication with patients, particularly on arrival at the ED, manage expectations. 3. Review written discharge instructions should be simple and easy to understand and translated where necessary. 4. Provide Frequently Asked Question (FAQ) sheets to answer the most commonly asked questions. 5. Budget enough time for questions after patients and families have reviewed written material and have had a chance to absorb the information. 6. Use different media (e.g., patient videos) to explain complex information to patients. 7. Use the "teach-back" method to ensure that patients understand instructions. 8. Offer reassurance that there are no "bad" questions. 9. Improve staff and provider customer service and interpersonal skills through clinically focused customer service training. 10. Develop and introduce cultural competence training to help staff understand the role culture plays in interactions between health care staff and patients and their families. 11. Develop and introduce educational strategies targeting prescribers, providing skill development in pain assessment and management in accordance with evidence-based, best practices, e.g., better understand drug-seeking behaviours, and don't overestimate the risk of addiction. 12. Evaluate feasibility of implementing Patient and Family Advisory Council. 13. Implement best practices enhancing	**1.** Monthly progress reviews conducted by Director Q/R. **2.** Quarterly QIP3 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	None.
		From NRC Picker: "Overall, how would you rate the care and services you received at the hospital?" (add together percent of those who responded "Excellent, Very Good and Good") Q3 2011/12 – Q2 2012/13	ER = 87.47% IP = 91.54%	ER = 91.8% IP = 96.4%		1				

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Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for Change Ideas (2013/14)	Comments
							Patient Safety Culture and associated with Senior Friendly Hospitals. 14. Implement Patient Relations monthly leadership walkabouts to engage patients/family members regarding their care experience. 15. The tools include easy to read information about risk factors, methods of screening, pros and cons of various approaches, and where to go for more information. 16. Involvement in treatment decisions. Encouraging people to manage their own chronic conditions and to feel they are in control of their health has also been shown to result in better health behaviours and health outcomes.			
		In-house survey (if available): provide the percent response to a summary question such as the "Willingness of patients to recommend the hospital to friends or family" (Please list the question and the range of possible responses when you return the QIP)	N/A	N/A	N/A	N/A				
Safety	Minimize preventable obstetrical injury	Canadian Hospital Reporting Project: Caesarean Section Rate (rate per 100) 2011-12	42.12%	2013/14, Q3/4 = 28.96%	Median National Adjusted Rate = 28.96%	1	**1.** Review and implement recommendations, as appropriate, of: • MSH-CARES: Markham Stouffville Hospital Caesarean Section Reduction Strategy. • BORN Ontario. • HIROC Obstetrics-Specific Risk Mitigation Strategies. • Maternal and Perinatal Death Review Committee. **2.** Evaluate impact of Managing Obstetrical Risk Efficiently ($MORE^{OB}$) Program and barriers to achieving full benefit.	**1.** Monthly progress reviews conducted by Director Q/R. **2.** Quarterly QIP3 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	None.
		Canadian Hospital Reporting Project: Obstetric Trauma - Vaginal Delivery With Instrument (rate per 100) 2011-12	6.31%	2013/14, Q3/4 = 1.83%	Median National Adjusted Rate = 1.83%	1				
		BORN Ontario: Rate of episiotomy or $3^{rd}/4^{th}$ perineal laceration among women who had a vaginal birth 2011-12	Episiotomy = 20.6% Laceration = 9.2%	2013/14, Q3/4 = < 13%	BORN Ontario: Episiotomy Target < 13%	1				
Safety	Avoid Patient falls	**Falls**: Percent of complex continuing care residents who fell in the last 30 days - Q2, FY 2012/13, CCRS	4.7%		FY 2011/12 = 4.2%	2				

AIM		MEASURE					CHANGE			
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for Change Ideas (2013/14)**	**Comments**
	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 - Hospital-collected data, most recent quarter available (e.g., Q2 2012/13, Q3 2012/13) Newborn excluded.	(+ IP MH) Q2 2012/13 = 98.1% Q3 2012/13 = 98.6% (- IP MH) Q2 + Q3 2012/13 = 100%			2				
	Reduce hospital acquired infection rates	**CDI rate per 1,000 patient days**: Number of patients newly diagnosed with hospital-acquired CDI, divided by the number of patient days in that month, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	0.21%		Benchmark from provincial surveillance = 0.35%	2				
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial patient contact multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	McConnell Site 2012 Calendar Year = 53% Second Street Site 2012 Calendar Year = 90%	2013/14, Q3/4 = 80%	Provincial Average by Hospital Type (FY 2010/11): Teach = 73% Large = 71% Small = 74% C3/RH = 76% MH = 66% (HQO)	1	**1.** Renewal/redesign of HH program with accountabilities redefined, i.e., Executive, Director/Manager, IPAC, Front-Line HCPs as well as reporting mechanisms and frequency: • HH mandatory training, including performing audits of front-line HCPs provided to each clinical manager. • Clinical managers encouraged/ supported in developing other unit-based incentives to recognize top performers. • Unit specific HH results posted and HH posters placed in unit high visibility/ traffic areas. • HH incorporated into corporate and unit-based orientation. • All admitted patients are educated by MD and care team about HH: "It's OK to Ask". • HH standing agenda item with HCP staff meetings. • CNO/VP visits to recognize and incent clinical units achieving ≥ 80% HCP compliance within submitted monthly audits. • Leadership Walkabouts encourage HH dialogue and awareness.	**1.** Monthly progress reviews conducted by Director Q/R. **2.** Quarterly QIP3 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	None.

AIM		MEASURE					CHANGE			
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for Change Ideas (2013/14)	Comments
							• HH incorporated within Position Descriptions and Performance Appraisals. • Periodic assessments of hand sanitizer access/ placement so sanitizer is part of the workflow area. • Regular staff rounding, coaching, immediately counseling with observed/ reported performance shortfalls. • HH individual HCP training provided by IPAC lead with two or more incidents of observed non-compliance. • HH mandatory annual refreshers scheduled with compliance monitored/ managed - HH e-learning module available to support completion of mandatory annual refreshers. • Unit HH champion(s) identified, mentor and facilitate "positive deviance" strategy.			
		Rate of central line blood stream infections per 1,000 central line days: total number of newly diagnosed CLI cases in the ICU after at least 48 hours of being placed on a central line, divided by the number of central line days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	5.00% (only 1 incident)	0.52%	Benchmark from CCIS - Provincial average = 0.52%	2				
		VAP rate per 1,000 ventilator days: the total number of newly diagnosed VAP cases in the ICU after at least 48 hours of mechanical ventilation, divided by the number of ventilator days in that reporting period, multiplied by 1,000 - Average for Jan-Dec. 2012, consistent with publicly reportable patient safety data	FY 2011/12 = 0.00%	0.00%	Benchmark from CCIS - Provincial average = 1.07%	2				

AIM		MEASURE					CHANGE			
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for Change Ideas (2013/14)	Comments
Safety	Reduce incidence of new pressure ulcers	Pressure Ulcers: Percent of complex continuing care residents with new pressure ulcer in the last three months (stage 2 or higher) Q2, FY 2012/13, CCRS				2				
	Reduce rates of deaths and complications associated with surgical care	**Rate of in-hospital mortality following major surgery**: The rate of in-hospital deaths due to all causes occurring within five days of major surgery - FY 2011/12, CIHI CHRP eReporting tool Following consultation with HQO, indicator amended to include only CCH inhospital mortality and exclude transfers out within 5-day timeframe.	CIHI/CHRP Report – FY2011/12 Adjusted Rate = 9.37% DAD Report Generator FY 2011/12 = 10.31%		CHRP Data Report FY 2011/12 Adjusted Peer = 8.55% Region = 7.77% National =8.62% Provincial =9.18%	1	**1.** Review and implement recommendations, as appropriate, of : • HIROC Surgery/Intensive Care-Specific Risk Mitigation Strategies. **2.** Evaluate and manage compliance rates with Safer Healthcare Now! evidence-based interventions and "bundles" relevant to perioperative/surgical services' patient safety outcomes: • AMI: Acute Myocardial Infarction. • IPAC: Infection Prevention and Control. • CLABSI: Central Line-Associated Bloodstream Infection. • MedRec: Medication Reconciliation. • ERT/RRT: Rapid Response Teams. • SSI: Surgical Site Infection. • VAP: Ventilator-Associated Pneumonia. • VTE: Venous Thromboembolism. • SSSL: Safe Surgery Saves Lives/ Surgical Safety Checklist. **3.** Identify patient profiles at-risk: • age (very young and older); • comorbidities (ASA Physical Status) • emergency/trauma • perioperative AE/postoperative ICU admission • need for invasive monitoring • higher risk and complex procedures **4.** Introduce and test targeted risk prevention/ mitigation strategies, i.e., operative delay in older patients with hip fracture is associated with a higher risk of post-operative complications and mortality. **5.** Evaluate higher-risk surgeries to ensure maintenance of "threshold volume" of cases, i.e., currently, in cardiac care, there are minimum standards for facilities that are being followed, these standards	**1.** Monthly progress reviews conducted by Director Q/R. **2.** Quarterly QIP3 Scorecard presented to Senior Leadership Team, Medical Quality Committee and Quality and Performance Monitoring Committee.	Implemented process measures expected to provide timely notice of intervention effectiveness or if a recovery plan required at the operational, executive and governance levels.	None.

AIM		MEASURE					CHANGE			
Quality Dimension	**Objective**	**Measure/Indicator**	**Current Performance**	**Target for 2013/14**	**Target Justification**	**Priority level**	**Planned Improvement Initiative (change ideas)**	**Methods and Process Measures**	**Goal for Change Ideas (2013/14)**	**Comments**
							include minimum volumes of surgeries, a minimum number of surgeons and a minimum of necessary physical resources and human resources that must be available. **6.** Ensure CCH Physician Recruitment Impact Analysis Form captures whether new or additional procedures be performed beyond those currently available, implications for perioperative/ surgical HCP skill mix and experience as well as other resource requirements to assure patient safety. **7.** Evaluate perioperative/surgical HCP core patient safety knowledge/skills: **8.** Failure to rescue: Warning signs of rapid deterioration, e.g., HCPs awareness of patient impact of sepsis, i.e., a leading cause of in-hospital mortality; a study of 12 Canadian community and teaching hospital critical care units found that mortality for patients with severe sepsis was just more than 38%. • Communication techniques: Situation-background-assessment-recommendation (SBAR); concerned-uncomfortable-unsafe-scared. • Patient safety culture: critical within the complex perioperative environment, involving multiple teams of caregivers and transitions of care. **9.** Physician chart audits of all deaths meeting criteria with report and recommendations to Medical Quality Committee.			
		Surgical Safety Checklist: number of times all three phases of the surgical safety checklist was performed ('briefing', 'time out' and 'debriefing') divided by the total number of surgeries performed, multiplied by 100 - Jan-Dec. 2012, consistent with publicly reportable patient safety data	Dec-2012 Not Available Jan-Nov-2012 = 98.9% FY 2011/12 = 99.6%		Benchmark Provincial Average for FY2011/12 = 99.5%	2				

AIM		MEASURE					CHANGE			
Quality Dimension	Objective	Measure/Indicator	Current Performance	Target for 2013/14	Target Justification	Priority level	Planned Improvement Initiative (change ideas)	Methods and Process Measures	Goal for Change Ideas (2013/14)	Comments
	Reduce use of physical restraints	Physical Restraints: The number of patients who are physically restrained at least once in the 3 days prior to a full admission divided by all cases with a full admission assessment - Q4 FY 2010/11 - Q3 FY 2011/12, OMHRS	5.9%		Q4 2010/11/ Q3 2011/12 Benchmark Average: Peer = 5.0% LHIN = 5.9% ON = 4.9%	2				