Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2019-03-07

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Ontario

Overview

Cornwall Community Hopsital is accountable for and committed to our Vision of "Exceptional Care. Always." As we near the end of our five-year Strategic Plan, we remain focused on our four Strategic Pillars, namely:

1) Partnering for patient safety and quality outcomes: We will partner with experts and our peers.
2) Patient inspired care: We will ensure the delivery of patient inspired care.
3) Our team, our strength: We will continue to develop and promote our team.
4) Operational excellence through innovation: We will reinforce our commitment to solid operational and financial performance.

The 2019 Quality Improvement Plan will continue to build on some of the initiatives from the previous year's Plan to further enhance the quality and safety of care delivered; reducing readmissions for Chronic Obstructive Pulmonary Disease (COPD), focusing on discharge information, and timely responsiveness to complaints.

The current provincial platform and priorities include the desire to address "hallway medicine", better support end of life care and to reduce wait times for people requiring access to mental health and addiction services. These provincial priorities very much align with the opportunities for improvement that Cornwall Community Hospital worked on in 2018. Our focus was and continues to be to improve wait times in the Emergency Department. Another corporate project focused on reducing length of stay and improving patient flow. There were many other undertakings that aligned with these projects. As an example, through feedback obtained from our patients, it was apparent that there was a need to focus on improving patient education and other relevant discharge information. The Hospital's budget in 2018-2019 was established to support all of these initiatives as investments were required for additional staff (e.g. discharge planners, physician assistant, patient flow coordinator) as well as a patient educational program entitled Healthwise©.

Cornwall Community Hospital serves a community that has some unique challenges. According to Cancer Care Ontario's report titled Cancer Risk Factors Atlas of Ontario (2017), there is a higher propensity for someone residing in Cornwall to have cancer for the following reasons: (1) the consumption of alcohol by males exceed cancer prevention recommendations (2) females in parts of Cornwall consume less vegetables and fruit and lastly (3) females have increased sedentary behavior and also have higher incidences of smoking.

The community that is served by Cornwall Community Hospital has a population of approximately 110,000 and includes the Akwesasne First Nations Community. Cornwall is among the 20% most deprived areas in Ontario; 47% of the population has post-secondary education and 14.5% are living below the low-income cut-off. Within the Champlain Local Health Integration Network, the Cornwall area is noted to have the highest rate of Chronic Obstructive Pulmonary Disease (COPD), the second highest stroke rate and a very high diabetes rate amongst the Indigenous population. Cornwall's population has a higher percentage of seniors residing in the area; 23.2% of the population is 65 years and older compared to the province at 16.7%. According to the 2016 Statistics Canada report, 41.7% of the residents of Cornwall speak both English and French.

Cornwall Community Hospital has a partial designation under the French Language Services Act; as such services provided to our community are provided in both official languages. There has also been a significant commitment to establishing a culturally competent health care environment for the Akwesasne First Nations Community. Just this year, approximately 15% of the staff have participated in indigenous cultural awareness training. This is not unlike the Senior Friendly group that focuses on minimizing risk to seniors during their visits to the hospital.

The Hospital values the opportunity to work with the following community partners: The Ottawa Hospital, the Ottawa Heart Institute, the Ottawa Regional Cancer Centre, the Champlain LHIN Home and Community Care

Program, the Akwesasne Department of Health, the Cornwall Police Services, the Royal Ottawa Hospital, the Eastern Ontario Health Unit, St. Joseph's Continuing Care Centre, Glengarry Memorial Hospital and Winchester District Memorial Hospital. We are fortunate to have been able to recruit a resident of Akwesasne as a Board member. In addition, the Hospital has created a partnership with the Seaway Valley Community Health Centre to reduce Chronic Obstructive Pulmonary Disease (COPD) admissions and with the Children's Hospital of Eastern Ontario (CHEO) to treat diabetic children bringing "care closer to home". Cornwall Community Hospital works collaboratively with St. Joseph's Continuing Care Centre establishing a transitional plan to reduce the likelihood of patients requiring long-term care placement from the hospital setting. Finally, the Hospital works closely with Cornwall Hospice that is able to provide holistic end of life care in a residential setting.

Over the past year, many of the dedicated physicians retired and it continues to be a challenge to recruit some medical specialists most notably psychiatrists, hospitalists and emergency physicians. This challenge is not unique to Cornwall as there is a significant shortage of psychiatrists across Ontario. It should also be noted that access to primary care in the community is challenging; Cornwall is identified by the Ministry of Health and Long-Term Care as being an "area of high physician need". This impacts access to care, for example there are times when establishing safe discharge plans for patients becomes challenging because a majority of patients are unlikely to have access to their primary care physicians within seven (7) days of discharge (as is suggested for many patients with specific chronic illnesses).

Our selection of key performance indicators has been informed by these environmental factors. In order to support the 2019-2020 Quality Improvement Plan, Cornwall Community Hospital will strive to further improve the capacity of the organization's quality agenda by focusing on the indicators below. These are priority (P) or mandatory (M) indicators as defined by Health Quality Ontario.

- Number of inpatients receiving care in unconventional spaces (P)
- Time to Inpatient Bed (M)
- Patient Experience regarding information received at discharge (P)
- Complaint acknowledgement (P)
- Number of Violence Incidents (M)
- Medication reconciliation at discharge (P)

Describe your organization's greatest QI achievement from the past year

Our hospital is partnering with the Cornwall and District Family Support Group in a project funded by The Change Foundation to improve the interaction between family caregivers and the addiction and mental health system. As part of this project, called Embrace, the Hospital set out to change the way health providers in the Inpatient Mental Health Unit include family caregivers in planning and preparing for the discharge of their loved one. Through a true co-design framework, caregivers and providers were brought together to develop and implement three change ideas to support this initiative.

#1. As part of the Changing CARE project with The Change Foundation, Cornwall Community Hospital collaborated with three other projects in the province to create staff training modules on the value of caregivers, communicating with caregivers and empowering caregivers. This on-line training is mandatory for our staff working in the area of addiction and mental health. We are collaborating on the development of an additional module which will be specific to caregivers of someone with an addiction and/or mental health issue.

#2. Cornwall Community Hospital staff indicated that they do not always know who the caregiver for a particular patient is. We undertook a project called "Mission Recognition" to formally identify caregivers by welcoming them to the unit, giving them an identification badge and greatly enhancing our caregiver welcome package.

#3. Once caregivers are identified, the discharge process was redesigned so health providers seek out the patient's caregiver(s) days prior to discharge from the unit, as our "Mission Transition" project. Caregivers and providers together ensure that the caregiver is ready in advance of the patient's discharge by referring to a checklist throughout the patient stay so that the caregiver has the information they need (diagnosis, behaviours to expect, medications, follow-up appointments) and that both the patient and the caregiver will be safe after discharge.

Cornwall Community Hospital became one of the few hospitals in Canada to implement a fully integrated electronic health record in 2016. In August 2018, Canadian Healthcare Technology recognized the Hospital for the work done in creating a near paperless environment support to optimize patient care. The electronic health record continues to be optimized to enhance patient safety at many levels. As an example, the electronic health record is utilized to prompt the nurse to identify a caregiver. The electronic health record has provided an effective means of leveraging the Changing CARE project.

Patient/client/resident partnering and relations

One of Cornwall Community Hospital's strategic goals is to improve the delivery of patient inspired care. We strive to identify patient needs as this is the core of our business; measuring and improving quality; and improving transitions into and out of hospital. Throughout the year, Cornwall Community Hospital provides quarterly progress reports on the Quality Improvement Plan indicators to the Quality and Performance Monitoring Committee of the Board and the Board of Directors. The 2018-2019 Quality Improvement Plan was developed with feedback from Patient and Caregiver Experience Advisors, the Quality and Performance Monitoring Committee, the Medical Advisory Committee and the Board of Directors.

The focus has and continues to be to respond to patients and families when there is a real or perceived gap in care, coordination or communication. Our Patient Experience Specialist ensures that the voice of the patient is heard and influences planning and decision-making on issues that affect patient care, ensuring the needs and expectations of patients and their families are addressed. For a number of years now, there has been a very active Mental Health Family Advisory Council that focuses on the needs of families both in the Community Mental Health Programs as well the Inpatient Mental Health unit.

The Hospital has expanded its Patient Experience Program and regrouped advisors to form the Patient and Caregiver Experience Advisory Council. The Council is comprised of 10 advisors with previous patient or caregiver experience, who generously provide their time to further our goal of improving the patient experience. Just this year, they have provided feedback on patient education, the hospital complaint and disclosure process, and visiting hours. They participated and provided feedback on wayfinding and they are members on numerous committees (e.g. Ethics, Falls, Accessibility, Quality and Performance Monitoring Committee of the Board). Patient and family input is collected through a variety of mechanisms including impromptu online surveys, solicited inpatient and outpatient surveys, the electronic patient incident reporting process, the Patient Experience Specialist, our physician and front-line staff's day-to-day interactions. The Canadian Institute for Health Information (CIHI) patient satisfaction survey data has been carefully analyzed to identify areas where our patients are telling us we can do better. The top three and bottom three survey performers are shared each quarter with department managers and with the Quality and Performance Monitoring Committee so they can celebrate good results and work to improve the others. Survey results continue to support the need for the hospital to remain focused on the information provided at the time of discharge. In response, the Hospital has enhanced the patient handbook to make it more user-friendly for our patient population.

Some areas of the hospital have created their own surveys to solicit information that is most relevant to their program. This includes Women and Children's Health Services, the Critical Care Unit, Diagnostic Services and the Ontario Perception of Care Tool that is used both in the Community Mental Health Programs and Inpatient

Mental Health.

Workplace Violence Prevention

Recent workplace violence incidents in health care have highlighted the need for increased diligence in this area and a focus group, which included members of Senior Administration was introduced in January 2015. This group has been meeting monthly to advance this important agenda. The hospital has a zero-tolerance policy to violence (or the threat of violence) against staff or physicians.

This focus group was transformed into the Workplace Violence Prevention Committee with increased staff participation, and is chaired by the Chief Executive Officer. Violence in the workplace is a standing item for both the Joint Health and Safety Committee (JHSC) as well as for the Senior Administration Team.

Policy and program updates included an in-depth review of the Non-Violent Crisis Intervention training program for effectiveness and suitability and of the Code White policy, which includes use of force by security guards; the development of a process working with community partners to case manage high risk clients presenting to Cornwall Community Hospital as well as the adoption of the toolkits from the Public Services Health and Safety Association (PSHSA). The toolkits from this Association form the basis of the workplan for the Workplace Violence Prevention committee.

Recently an "acting out behavior" policy was developed. The policy establishes a process to identify any patient that has the potential for violence to be flagged in the electronic health record to alert the healthcare providers of a risk.

Physical environment improvements include a seclusion room renovation in the Emergency Department (ED); Code White buttons for nurse call at three triage stations in the Emergency Department; new security force in place with increased standards for the role of guards that include hand cuffs, vests, and belts; and a modification in guard hours to facilitate maximum coverage. The building is locked down at night and anyone entering during that time must be authorized by security. As next steps, the hospital is reviewing personal safety response systems for community programs (whereby staff are required to enter client's homes), Emergency Department and the Inpatient Mental Health unit.

Going forward, the Committee will continue to assess our progress regularly to ensure that initiatives/ improvements are implemented with the goal of keeping staff, physicians and patients safe. At all times, staff and physicians are encouraged to report concerns and offer suggestions to mitigate the potential for violence.

Executive Compensation

Cornwall Community Hospital performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role are linked to achieving targets in the Quality Improvement Plan as per the Excellent Care for All Act (ECFAA) requirements.

The achievement of the annual targets for the Quality Improvement Plan indicators outlined below account for a total of 2% of the overall compensation for the chief executive officer and the executives below. Payments will be determined by assigning comparable weights to each indicator, and the use of a sliding scale for the percentage of target achieved.

- President and Chief Executive Officer
- Vice-President, Patient Services and Chief Nursing Officer
- Vice-President, Community Programs

- Chief Financial Officer
- Chief Information Officer
- Chief Privacy and Human Resources Officer
- Senior Director, Critical Care and Perioperative Services
- Chief of Staff

Quality Improvement Plan Indicators:

1. Number of inpatients receiving care in unconventional spaces
2. Time to Inpatient Bed
3. Patient Experience regarding information received at discharge
4. Complaint acknowledgement
5. Number of Violence Incidents
6. Medication reconciliation at discharge

Contact Information

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Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan.

Nancee Cruickshank
Board Chair

William A. Knight
Chair
Quality and Performance
Monitoring Committee

Jeanette Despatie
Chief Executive Officer

2019/20 Quality Improvement Plan
"Improvement Targets and Initiatives"

Cornwall Community Hospital 840 McConnell Avenue

03/07/2019

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Efficient**	Average number of inpatients receiving care in unconventional spaces or ER stretchers per day within a given time period.	P	Count / All patients	Daily BCS / October - December 2018	967*	X	1.00	New indicator; target established at an average of 1 per day.		1)Continue to work with the Chiefs to align Length of Stay (LOS) with Expected Length of Stay (ELOS) targets established in Quality Based Procedures (QBP) handbooks.	Provide Chiefs and Department Managers Length of Stay (LOS) reports.	Length of Stay (LOS)/ Expected Length of Stay (ELOS).	Length of Stay = Expected Length of Stay (ELOS) unless variance supported by documentation.	Length of Stay (LOS) that exceed target should be tracked when gaps in the system. (In order to protect patient privacy "X" is used when there are any indicators with numerator less than 5 and denominator less than 30)
											2)Adopt underlying principle that ER should have zero patients admitted.	Data to be tracked and reported to the Length of Stay Working Group by the Patient Flow Manager.	Bed Management report reports number of admits in ER.	That on average, 100% of patients will be admitted to a conventional bed.	
											3)Encourage chiefs to transfer patients to rural hospitals that have capacity.	Number of patients repatriated from ER to HGMH or WDMH.	Track occupancy of other hospitals utilizing the LHIN Daily Flow Depot.	That when occupancy is greater than 90%, patients will be transferred to a rural hospital.	
											4)Establish guidelines for internal escalation procedures when occupancy is high (surge plan).	Number of staff that demonstrated understanding of surge plan.	Track through the daily census report when occupancy is greater than 102%.	By May 1, 2019, all department chiefs will be informed of plan.	
											5)Level out the number of surgical cases over 5-day elective booking period.	Number of cases by day of the week.	Track the number of OR cancellations related to shortage of surgical beds.	That by July 1, 2019 0 (zero) cases cancelled.	
	Timely	**The time interval between the Disposition Date/Time (as determined by the main service provider) and the Date/Time Patient Left Emergency Department (ED) for admission to an inpatient bed or operating room.**	**MANDATORY**	**Hours / All patients**	**CIHI NACRS / October 2018 – December 2018**	**967***	**16.07**	**23.20**	**New indicator. Target established at 10% reduction of High-Volume Community Hospital Group performance of 25.8 for Fiscal Year 2017-2018. (formula is 25.8*(1-10%)=23.2). *CCH performance**		**1)Early discharge planning is embraced as part of organizational culture and philosophy of care.**	**Continue with the corporate project of monitoring Time to InPatient Bed (TIB) with a goal of meeting or exceeding target.**	**Track the metrics for Time to InPatient bed using the Daily Access Reporting Tool (DART).**	**That by Q 1, 2 - TIB will be less than or equal to 16.2**	**Target justification is aggressive as performance excellent in q1-3; typically more challenging in q4 (*Formula is 23.8 * (1 - 5%) =22.6)**
											2)Continue recruitment of hospitalists to better manage workloads.	Hospitalist working group to monitor volume of patients per physician.	Track the number of patients per hospitalist related to number of discharges	By July 1, 2019, hospitalist case load not to exceed 27 patients (Monday - Friday)	

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
									for same period (FY2017-18) was 41.2.		3)Realign hospital services to ER activity.	Daily review of DART - TIB.	Track the number of times that target for TIB is not met.	By the end of Q2, TIB less than or equal to 16.2	
											4)Advocate to LHIN for greater access to care coordinators and to demand for beds.	Track the number of CCAC referrals from ED (ED/CCAC notifications).	Track the number of hospital admissions avoidedrelated to CCAC Geriatric Emergency Nurses involvement.	All patients receiving home care services to be reassessed within 72 hours.	
Theme II: Service Excellence	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within five business days	P	% / All patients	Local data collection / Most recent 12 month period	967*	83.33	89.25	Target established at 89.25%; A 5% increase to prior year target of 85%. (formula is 85.0% *(1+5%) = 89.25%)		1)Actively involve Patient and Caregiver Experience Advisors at departmental level to promote patient inspired care.	Number of departments that have advisors as participants.	Track number of complaints in each department that advisors provided feedback on system improvements.	Track and report at the Patient and Caregiver Experience Advisory Council.	
											2)Update corporate policy defining expectations of managers and educate leadership team on expectations.	Compliance with policy (defining) expectations to be reported at management meetings and Quality Performance Monitoring Committee (of the Board).	Percentage of complaints that have been responded to within 5 days.	During 2019/20, the hospital will acknowledge complaints 89.25% of the time within 5 days.	
											3)Utilize incident reporting system to alert Quality department if complaint has not been acknowledged in 3 days.	Compliance with policy (defining) expectations to be reported at management meetings and Quality Performance Monitoring Committee (of the Board).	Percentage of complaints that have been responded to within 5 days.	During 2019/20, the hospital will acknowledge complaints 89.25% of the time within 5 days.	
											4)Establish new training program for all staff to improve the patient experience that may influence the number of complaints received.	Review of monthly reports generated through the incident management system (RL6).	Number of staff that participate in updated corporate training (mandatory).	By November 2019 30% of staff will have participated in training that focuses on improving the patient experience (and 60% by March 31, 2020).	
		Patient Experience: Did you receive enough information when you left the hospital? Inpatient (**Top 2 Box)	C	Percentage/**Top 2 Box (Completely and Quite a Bit) / All inpatients	NRC Picker / Most Recent 12 Months	967*	73.4	78.00	Target established at 78%; A 5% increase to prior year target of 75%		1)Educate all nursing staff on the merit of Patient Oriented Discharge Summaries (PODS).	Audit the update of PODS through the electronic health record.	Number of patients that responded positively (Top 2 Boxes) to NRC Patient Satisfaction Survey.	By June 1, 2019 40% of patients on the Medicine unit will receive PODS information on discharge.	
											2)Educate staff and physicians about Healthwise.	Audit the uptake through the electronic health record.	Number of patients that responded positively (Top 2 Box) to NRC Patient Satisfaction Survey.	By June 1, 2019, 40% of patients on Medicine unit will have received Healthwise	
											3)Embed the University of Ottawa Heart Institute's Guidelines Applied into Practice (GAP) tools for Chronic Heart Failure (CHF) and Acute Coronary Syndrome (ACS).	GAP tool compliance to be reviewed internally by managers and the Critical Care Committee (Q2 2018/19 at 100%).	Track number of patients that received GAP patient discharge information.	By July 1, 2019 90% of patients will receive information Ottawa Heart Institute provided.	
Theme III: Safe and Effective Care	**Effective**	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / October - December 2018	967*	85.66	85.00	Continue to maintain or exceed prior Fiscal Year 2018-2019 performance. Target is set 16% higher than our		1)Optimize information shared with community partners obtained via medication reconciliation at discharge to promote patient safety.	Track the number of fax referrals that were made from CCH to community pharmacies and primary care practitioners.	Number of e-referrals or fax made to community pharmacies or primary care practitioners.	85% of patients will have medication reconciliation completed on discharge by June 2019.	

AIM		Measure									Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	External Collaborators	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure	Comments
		proportion the total number of patients discharged.							Peer Comparative Hospital average target of 73%.		2)Leverage technology to improve medication information from hospital to primary care practitioners at the time of patient discharge.	Audits through the electronic health record.	Number of (e-referrals or faxes) made to primary care practitioners.	85% of patients will have medication reconciliation completed at discharge.	
											3)Embed in Patient Handbook and hospital website "Five Questions to Ask About Your Medications?" (I.S.M.P.)	Empower patients to better understand their medication prescriptions at discharge	Track patients response to "did you receive enough information at discharge?"	78% of patient respondents to NRC Patient Satisfaction Survey indicates positive results.	
											4)Promote awareness of polypharmacy when preparing discharge prescriptions (Senior Friendly Initiative) at Medical Grand Rounds.	Report on the topics presented at Medical Grand Rounds.	Track number of patients discharged that are greater than or equal to 65 year of age that have medication reconciliation.	85% of seniors will have medication reconciliation completed on discharge.	
	Safe	**Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period.**	**MANDATORY**	**Count / Worker**	**Local data collection / January - December 2018**	**967***	**233**	**210.00**	**Baseline established and new target consistent with 10% reduction to last years performance of 233. (formula is 233*(1-10%) =210)**		**1)Continue on and report on progress made utilizing the various tool kits to promote safety; risk assessments, individual chart risk assessment, flagging security and personal safety response systems. Optimize information that has transferred from police to ER department Health IM (policy software purchased by police) to establish safety plans for staff.**	**Tracking through the Police Liaison Committee the number of patients brought to ER by Cornwall Police Services wherein Health IM has been utilized.**	**The number of times a patient in ER is restrained (as reported through the electronic incident reporting system).**	**To decrease the number of reported incidents of violence by 10% by March 31, 2020.**	**FTE=860**
											2)Support staff navigate the judicial system when charges are laid against a patient or external perpetrator.	Number of incidents that result in personal injury or damage to hospital property.	Track number of assaults or threats that result in charges being laid.	Track through the Police Liaison Committee.	
											3)Continue to evaluate the efficacy of training programs delivered by the hospital.	Obtain feedback from staff.	Track compliance of mandatory Nonviolent Crisis Intervention Awareness (NVCI)Training through the Learning Management System (LMS).	By September 2019 70% of all staff will be compliant and by January 2020 0% of all staff will be trained in NVCI.	
											4)Work with Patient and Caregiver Experience Advisors (PCEAC) to develop information in Patient Handbook. Engage patients and families in Workplace Violence Prevention: a handbook for organizational leaders in healthcare.	Utilize the materials from Public Services Health & Safety Association to educate patients.	Track the number of patients through the electronic health record that are flagged in six (6) months with Acting out Behaviour (AOB).	Track updates at the Patient and Caregiver Experience Advisory Council (completion by January 2020). Report on AOB to be received by PCEAC.	