Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

2025-2026

OVERVIEW

Established in 2004, Cornwall Community Hospital (CCH) remains dedicated to its vision of delivering "Exceptional Care. Always" by fostering a culture of quality and safety. The hospital serves a diverse community of over 110,000 residents, including those in the City of Cornwall, the United Counties of Stormont, Dundas, Glengarry, and the Mohawk community of Akwesasne. Offering a full spectrum of acute care and community services, CCH is committed to providing people-centered care, guided by its ICARE values: Integrity, Compassion, Accountability, Respect, and Engagement.

CCH proudly celebrates our Exemplary status awarded to our hospital by Accreditation Canada in 2024. This prestigious recognition reflects our ongoing commitment to maintaining the highest standards of care and continuous improvement in healthcare services. Achieving this status is a testament to the dedication of our staff, physicians, and leadership in ensuring that patient safety, quality care, and operational excellence remain at the forefront of everything we do. It also reinforces our unwavering focus on delivering exceptional care to the communities we serve.

Looking forward to the 2025/26 QIP, CCH is focused on priority issues including Access and Flow, Equity and Indigenous Health, Patient and Provider Experience, and Safety. The following are the QIP indicators for the coming year:

1) Wait time to physician initial assessment (PIA)

2) Ambulance offload time

3) Emergency Department length of stay for non-admitted patients with low acuity

4) Percentage of staff (all) who have completed relevant equity, diversity, inclusion, and anti-racism training

5) Percentage of patients that respond positively to the question "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?" on the Patient Experience Survey

6) Medication Scanning Compliance

ACCESS AND FLOW

CCH prioritizes timely access to hospital services, as outlined in our Strategic Priority of Enhancing Access to Care. We are committed to ensuring that patients receive high-quality, safe care in the right setting and at the right time. To drive systemic improvements in access and flow, we focus on optimizing care transitions by implementing timely and effective discharge planning, preventative measures for admissions and readmissions, and reducing Emergency Department wait times. This dedicated focus on access and flow is designed to enhance the quality of care, improve patient and family satisfaction, and lead to better health outcomes.

With the integration of the Emergency Department Return Visit Quality Program (EDRVQP) into the QIP in 2025/2026, new emergency department related indicators that are aligned with the emergency department Pay-for-Result program will be a focus. The goal is to bring a continuous structure of quality improvement into the emergency department. CCH aims to prioritize opportunities and focus resource investments to improve access to services and flow throughout the healthcare system.

EQUITY AND INDIGENOUS HEALTH

CCH continues to demonstrate its commitment to fostering Equity, Diversity, Inclusion, (EDI) and anti-racism throughout the organization. Following our EDI Framework, CCH is dedicated to providing the highest standard of care and promoting the best health outcomes. The advancement of EDI and anti-racism is a long-term commitment which requires the thoughtful consideration of the experiences and views of all patients, clients, staff, and people in our community.

To showcase our dedication, this past year our management team completed a series of continuing professional development courses that included sessions on Cultural Competence in Healthcare, Aboriginal and Political Governance, First Nations, Inuit and Metis Culture, Colonization and the Determinants of Health, and the Truth and Reconciliation Commission of Canada and the Declaration of the Rights of Indigenous Peoples. Through this education, we aim to understand our role in fostering a culturally safe healthcare system for Indigenous peoples and explore ways to contribute to dismantling colonial structures in healthcare and beyond.

Building on our commitment to EDI (Equity, Diversity, and Inclusion) and anti-racism initiatives, we successfully completed mandatory training for all management and department chiefs this past year. The course was designed to promote an inclusive culture, develop essential skills, and provide strategies for fostering personal responsibility towards EDI in the workplace, while also raising awareness.

In the coming year, we are expanding our EDI training to include all staff and volunteers. By equipping employees and volunteers with an understanding of the historical, social, and organizational contexts surrounding EDI, we aim to deepen their awareness of the challenges and opportunities faced by our patients, families, and community. The ultimate goal of this training is to create a more inclusive and supportive work environment where every individual feels valued and empowered to contribute their unique perspectives and talents.

PATIENT/CLIENT/RESIDENT EXPERIENCE

CCH understands that a positive patient or client experience plays a crucial role in improving safety outcomes. Our goal is to provide care that is centered around the individual, ensuring it is culturally safe and aligns with their preferences, needs, and values.

To achieve this goal, CCH actively includes the voices of patients and families in our quality improvement efforts through our established Patient and Family Advisory Committee (PFAC). PFAC members contribute to various working groups and committees across the organization, offering valuable perspectives that help shape services and programs to better serve the needs of our community.

We recognize that measuring the patient's experience is integral to helping us advance our culture of people-centered care. We continue to leverage Patient Experience Surveys to gain insight into the experience of our patients, the strengths, and weaknesses of our healthcare system, and help us to identify areas for improvement. This valuable information has, and will continue to, help us identify patterns and trends, set measurable goals, implement targeted interventions, and continuously monitor progress.

A key initiative embraced by clinical managers is regular patient rounding, a vital practice in healthcare that involves systematic visits to patients' bedside to engage with them directly and understand their experience firsthand. This comprehensive approach allows healthcare teams to assess, communicate, and respond to patient needs while ensuring safety. It facilitates the early identification of health concerns and potential safety issues, enabling timely interventions that contribute to improved care outcomes and experiences. Regular monitoring of patient rounding

and its results helps managers identify trends and uncover opportunities for ongoing improvement.

PROVIDER EXPERIENCE

CCH is staffed with approximately 219 credentialed professionals, 1360 staff and 195 volunteers, all of which are integral to the organization. Improving the provider's experience in healthcare is crucial for both staff well-being and the overall quality of patient care. Healthcare providers who feel supported, engaged, and valued are more likely to deliver higher-quality care, have better patient outcomes, and experience lower levels of burnout. CCH works to support its providers by fostering a collaborative work environment, providing adequate staffing and resources, promoting a culture of recognition and appreciation, and leveraging programs and initiatives to improve provider satisfaction.

Several initiatives have been implemented to better support staff including the Clinical Scholar program, designed to provide support and mentorship to novice nurses. The program empowers experienced frontline nurses to facilitate learning and professional development for newly graduated nurses, internationally educated nurses, and those wanting to expand their nursing skills.

In addition, CCH continues its Enhanced Clinical Extern program, a Ministry funded initiative that brings regulated health professional students into the hospital to assist staff with day-to-day clinical work. This program not only provides valuable hands-on experience for students, but also helps alleviate the workload of existing staff, allowing them to focus on more complex patient care tasks. By integrating students into clinical teams, CCH fosters a collaborative learning environment, which enhances the quality of care and supports the development of the next generation of healthcare professionals. Furthermore, the program strengthens the hospital's capacity to deliver high-quality care while contributing to workforce development in the healthcare sector.

CCH regularly acknowledges and celebrates the contributions of its providers through a formal recognition program, Staff Appreciation Week, peer to peer gratitude initiatives “Cheers for Peers”, and notes of appreciation through our ICARE cards. Feeling valued and appreciated boosts morale and creates a positive work culture.

SAFETY

In efforts to create and sustain a culture of safety and to prevent or reduce patient safety events, CCH continues to focus on improving medication management through barcode scanning technology. Leveraging this technology can significantly enhance patient safety by accurate identification of patients and medications. It helps prevent medication errors, misidentification of patients reducing the potential for adverse health events. Robust medication management processes, including medication barcode scanning, can improve communication within the healthcare team and enable efficient coordination and collaboration among healthcare providers, promoting patient care and safety.

CCH has strengthened its commitment to medication scanning by implementing real-time reporting for managers, launching staff recognition programs, and conducting education and awareness campaigns. Additionally, root cause analysis is being used to identify and address barriers to adherence. In the coming year, these initiatives will remain a central focus, with the added component of patient engagement. Management will conduct regular patient rounding to foster open conversations about medication scanning adherence and to enhance patient understanding of its importance, further reinforcing the hospital's commitment to safety and quality care.

PALLIATIVE CARE

Ontario Health's Quality Standard for Palliative Care serves as a guide to CCH as we work to address the unique care needs of adults with a progressive, life-limiting illness, and for their family and caregivers.

A newly reintroduced Palliative Care Committee, comprised of frontline staff, clinical managers, and patient and family advisors, is beginning work on organizational readiness, policy review, and an evaluation of current state. Building a solid foundation of understanding the palliative care needs within the community, along with considering the patient and family experience, is essential for driving meaningful improvements.

With plans to assess staff competencies in a palliative care setting and identify educational needs, the Committee is committed to addressing these gaps and implementing targeted education plans to enhance staff knowledge, improve care delivery, and ensure high-quality palliative care for patients and families.

POPULATION HEALTH MANAGEMENT

CCH collaborates with the Great River Ontario Health Team on population health management to co-design proactive, integrated, and people-centered solutions that are cost-effective, equitable, and efficient. The aim is to address the health needs of individuals across the continuum of care and promote overall well-being.

In the fall of 2024, CCH partnered with the Great River OHT, St. Joseph's Continuing Care Centre, Glengarry Memorial Hospital, Winchester District Memorial Hospital, and Carefor to expand the Essential Caregiver Program. This expansion aims to provide

training on the program's principles and highlight the importance of caregiver inclusion in patient care across all participating sites, including staff, patients, and caregivers. This collaborative effort within the community reinforces the commitment to building strong partnerships between caregivers and healthcare providers, ultimately improving patient outcomes.

In 2025, CCH will launch a Naloxone Distribution Program in collaboration with the Eastern Ontario Health Unit to address the rising issue of substance use disorders in the region. This initiative is strongly supported by our Client Advisory Council and Family Advisory Council, reflecting our commitment to meeting the needs of the community. The program is a vital step in ensuring that individuals most at risk, along with their loved ones, have access to life-saving medication and the education necessary for its proper use.

CCH prides itself on strong partnerships within our community as we work collaboratively to address the health and social needs of our population.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

Many quality improvement initiatives were included in last year's EDRVQP audit. The introduction of Social Work (SW) in the Emergency Department (ED) has been a welcomed addition. The SW group in the ED has been able to improve the quality of care provided within our ED. We have been able to monitor the number of consults to SW per hour of the day to determine the distribution of our SW coverage hours in ED. This information within the ED will support the appropriate care to the appropriate patients, at the appropriate times.

We are pleased to share the results of our most recent audits conducted which includes a decrease in the number of patients who are returning to the ED for Mental Health and Substance Use related reason for visits, as shared below. SW in the ED has allowed our team to improve care and reduce ED return visits for both patient population groups

Our ED team was able to conduct approximately 53 audits as part of this EDRVQP. There were common themes found: return to the ED for Diagnostic Imaging (DI) services (5.7%), substance use (5.7%), mental health (5.7%), and patients who could have been supported through community partners (25%).

Patients returning to the ED for DI was a reoccurring theme for return visits. The ED has an updated process in place which allows patients in the ED to return the next day (during on-site coverage hours) to facilitate a scheduled procedure for Ultrasound or CT.

Leveraging supports in the community was a theme throughout in order to prevent return visits to the ED. The ED team has continued collaboration and extended our collaboration with community partners, such as the Community Paramedicine program.

A Safe Beds indicator was put into place within the ED for increased awareness of patients presenting to the ED to facilitate safe discharge back to this program

EXECUTIVE COMPENSATION

Cornwall Community Hospital performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role is 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 Operating Officer
- Chief of Staff

CONTACT INFORMATION/DESIGNATED LEAD

Kelly Shaw
Vice President Patient Services and Chief Nursing Officer
Kelly.shaw@cornwallhospital.ca

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 on March 6, 2025

Alice Wilson-Haramis, Board Chair

Kristen MacDonell, Board Quality Committee Chair

Jeanette Despatie, Chief Executive Officer

Natalie Bourgeois, EDRVQP lead

Kelly Shaw, Vice-President, Patient Services, and Chief Nursing Officer

Access and Flow

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / For ERNI hospitals: Dec 1, 2023, to Nov 30, 2024 (Q1 and Q2)	22.00	20.00	Set at 10% decrease in last year's performance	

Change Ideas

Change Idea #1 Provide timely access to care in the Emergency Department through the reduction of AOT.

Methods	Process measures	Target for process measure	Comments
The target will be met through collaborating with Community Partners, such as Emergency Medical Services (EMS), to review current shared workflows	90th percentile AOT	Q1-Discussions to continue with Community Partners in regards to AOT. Meetings to be scheduled throughout Q1-Q4 time period. Q2-Collaborate with Decision Support to further analyze data (data collection, data quality, etc.). Q3 Continued collaboration with the frontline staff in the ED and EMS regarding process improvements for AOT. Evaluate change(s). Q4 Target of 10% reduction in AOT will be met.	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	7.53	6.77	Set at 10% reduction in last year's performance	

Change Ideas

Change Idea #1 Provide timely access to care in the ED for low acuity reason for visits

Methods	Process measures	Target for process measure	Comments
The target will be met through process improvement and collaboration with Diagnostic Imaging (DI)-process in place for patients returning to the ED for DI.	90th percentile ED LOS non-admitted low acuity	Q1 Continued education and awareness of Return to ED for DI process. Algorithm outlining process to be created and shared. Q2 Evaluate process put into place. Make adjustments to process, as required. Q3 Increase number of available DI tests available daily, as staffing in DI permits. Q4 Continuous evaluation of process.	

Change Idea #2 Provide timely access to care in the ED for low acuity reason for visits

Methods	Process measures	Target for process measure	Comments
Medical Directives in the ED will be optimized and will in turn reduce the time spent for patients in the ED with low acuity reason for visits.	90th percentile ED LOS non-admitted low acuity	Q1 Increase education and awareness of Medical Directives in the ED. Explore opportunities for additional medical directives. Q2 If applicable, bring new/updated Medical Directives through the approval process. Q3 Continue to monitor compliance of the use of Medical Directives by staff in the ED. Q4- 10% reduction in 90th percentile PIA.	

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	5.08	5.00	Target is based on HSAA performance standard obligations	

Change Ideas

Change Idea #1 Provide timely access to care by the Emergency Department Physician (EDP) or Physician Assistant (PA), once Triaged in the Emergency Department (ED).

Methods	Process measures	Target for process measure	Comments
The target will be met through process improvement in the Triage process in the ED and through optimizing the PA role in the ED.	90th percentile PIA	Q1 Environmental scan regarding Triage in the ED to be conducted, with a particular focus on PIA. Engage stakeholders in PIA. Q2 Bring forward CI change requests for approval. Q3 Increase education and awareness of change(s) to the Triage process and powerform. Roll out change(s). Q4- Evaluate change(s). 10% reduction in 90th percentile PIA.	

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	87.72	85.00	Target set based on previous year. Expanding denominator population will increase challenges. Maintaining previous target.	

Change Ideas

Change Idea #1 Add training to mandatory list for all staff (excluding casual) and volunteers in Learning Management System (LMS).

Methods	Process measures	Target for process measure	Comments
Update LMS mandatory participant list	Automated generated LMS emails launch	In Q1, LMS update to be completed and profiles set to mandatory for EDI module	

Change Idea #2 Communicate to target audience mandatory training requirement

Methods	Process measures	Target for process measure	Comments
Communicate via automated LMS emails and management huddles	Automated emails from LMS Management team huddles	In Q1, LMS automated emails launched, general delivery email to target audience, management huddle reminder	

Change Idea #3 Monitor performance quarterly			
Methods	Process measures	Target for process measure	Comments
Review LMS training compliance report	Review data provided by compliance report	In Q1 reach 25% training completion; Q2 reach 50%; Q3 reach 75%, and reach 85% of target group trained by Q4	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” or “quite a bit” to the following question: 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	62.22	70.00	Consistently met 24/25 target of 70% with Top 2 Box responses. Will increase target for 25/26	

Change Ideas

Change Idea #1 Promote the use of Patient Oriented Discharge Summary (PODS) through the electronic health record

Methods	Process measures	Target for process measure	Comments
Audit the use of PODS through the electronic health record	Number of patients receiving PODS on discharge/number of discharges	By Q1, 75% of admitted patients receive a PODS on discharge home	Total Surveys Initiated: 490

Change Idea #2 Clinical Manager Patient Rounding to identify needed early interventions

Methods	Process measures	Target for process measure	Comments
Clinical Manager to round on minimum 5 patients per month using standard set of questions	Number of patients rounded per month per unit (admitted patients and ED)	By Q1, 75% of target met By Q2, 85% of target met	

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication Scanning Compliance	C	% / Other	In house data collection / fiscal year	79.30	85.70	Challenges meeting previous year target. Target to remain status quo.	

Change Ideas

Change Idea #1 Reinforce compliance monitoring

Methods	Process measures	Target for process measure	Comments
Monthly audits of rates per unit/staff	Managers to review monthly audits	By Q1, managers to review monthly audits	

Change Idea #2 Performance Recognition

Methods	Process measures	Target for process measure	Comments
Managers to continue performance recognition at department level	Managers to communicate and deliver performance recognition to staff	By Q1, managers to communicate and sustain performance recognition process	

Change Idea #3 Sustain improvements in barcode maintenance

Methods	Process measures	Target for process measure	Comments
Pharmacy to develop and implement a sustainable barcode maintenance process	Define structured process for barcode issue resolution	By Q1, process for barcode issue resolution implemented By Q2, process maintained	