Cornwall Community Hospital
Hôpital communautaire de Cornwall

CORPORATE SCORECARD 2023/2024

Vision: Exceptional Care. Always.

Mission: Our Team collaborates to provide exceptional patient-centered care

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

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

RECOVERY					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Clostridium Difficile (C.Diff) Incidence	HSAA/MoHLTC	Y	R	G	G
Current Ratio	HSAA	N/A	N/A	R	G
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	G	G	G	G
Emergency Visits - Wait Time for Non-Admitted High Acuity	HSAA/OPT	Y	R	G	G
Emergency Visits - Wait Time for Non-Admitted Low Acuity	HSAA/OPT	Y	R	G	G
Falls per 1,000 Patient Days	Senior Friendly	G	G	G	G
Readmissions within 30-Days for Select HIG Conditions	HSAA	G	G	G	G
Repeat ED Mental Health Visits	QIP/HSAA/MSAA	G	G	G	G
Typical Average Length of Stay (ALOS) for Hospitalists	Board/OPT	G	G	Y	Y
Total Margin	HSAA	N/A	N/A	R	G
Wait Time - CT Scans (Priority 2, 3, 4)	HSAA	R	Y	R	R
**Wait Time - CT Scans (Priority 2, 3)	Board	Y	G	G	G
Wait Time - Long Waiters for All Surgical Procedures	HSAA	G	G	G	G
Wait Time - MRI Scans (Priority 2, 3, 4)	HSAA	R	R	R	R
**Wait Time - MRI Scans (Priority 2, 3)	Board	R	G	G	G

INTEGRATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
ALC Throughput	HSAA	G	Y	Y	Y
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	Y	G	G	G
Incomplete Charts	Board	R	R	G	G
Medication Scanning Compliance	QIP	R	R	R	R
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	Y	G	Y	Y

PEOPLE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Complaints Acknowledged	Board	G	G	G	G
Indigenous Cultural Awareness	HSAA	G	G	Y	G
Workplace Violence Prevention - Incidents	QIP	Y	G	R	Y

Results:

Metric underperforming target	R
Metric within 10% of target	Y
Metric equal to or outperforming target	G
Data not available	N/A

Overall Indicator Performance:	Q1	Q2	Q3	Q4
% Indicators equal to or outperforming targets:	43%	62%	57%	70%
% Indicators within 10% of targets:	33%	10%	17%	17%
% Indicators underperforming targets:	24%	29%	26%	13%

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
Senior Friendly - Senior Friendly Initiative (HSAA)
QIP - Quality Improvement Plan

Return to Dashboard

Indicator: Current Ratio

Strategic Direction: RECOVERY

Definition: Current Ratio is a key measure of liquidity. It reflects to what extent short-term financial obligations can be met from short term assets. Current Ratio = Current Assets/Current Liabilities. Performance is reported cumulatively on a year-to-date basis.

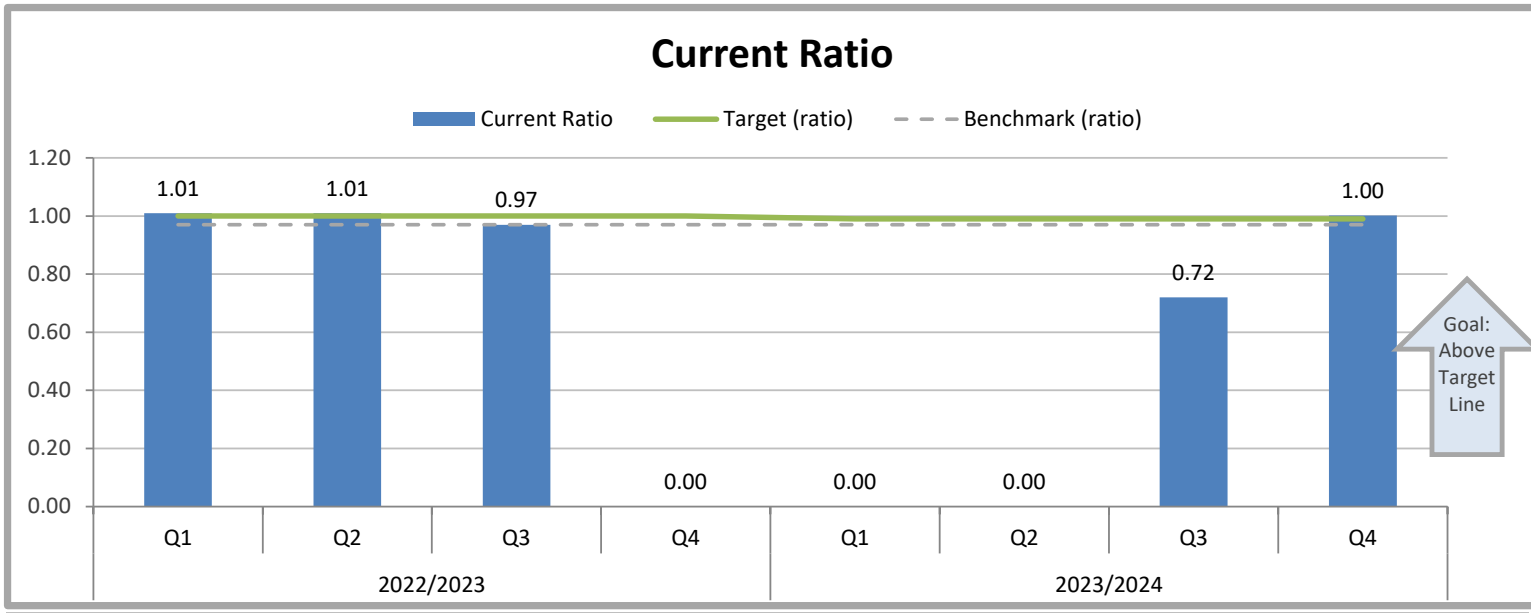
Significance: Indicates the overall financial health of the organization.

Data Source: Monthly Financial Statements - Balance Sheet

Target Information: Set according to HSAA obligations

Benchmark Information: Benchmark performance is based on prior fiscal year (Q1-Q2 cumulative) Champlain LHIN Hospitals performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Current Ratio	1.01	1.01	0.97	N/A	N/A	N/A	0.72	1.00
Benchmark (ratio)	0.97	0.97	0.97	0.97	0.97	0.97	0.97	0.97
Target (ratio)	1.00	1.00	1.00	1.00	0.99	0.99	0.99	0.99



Performance Analysis:

Q1 Results unavailable due to Cyber Incident and system failure (Virtuo).
Q2 Results unavailable due to Cyber Incident and system failure (Virtuo).
Q3 Target not met.
Q4 Target met.

Plans for Improvement:

Q1 Continue working on system recovery and backlog.
Q2 Continue working on system recovery and backlog.
Q3 Continue to work with Ontario Health for funding to cover Bill 124 go forward impact. Q4 will meet target.
Q4 Funding was received to cover Bill 124 go forward impact on a one-time basis. Advocacy work continues with OH to ensure funding is available for 2024-25.

Accountable: Chief Financial Officer / Director, Financial Services

Return to Dashboard

Indicator: Clostridium Difficile Incidence

Strategic Direction: RECOVERY

Definition: The hospital-wide rate of nosocomial Clostridium Difficile infection measured per 1000 patient days.

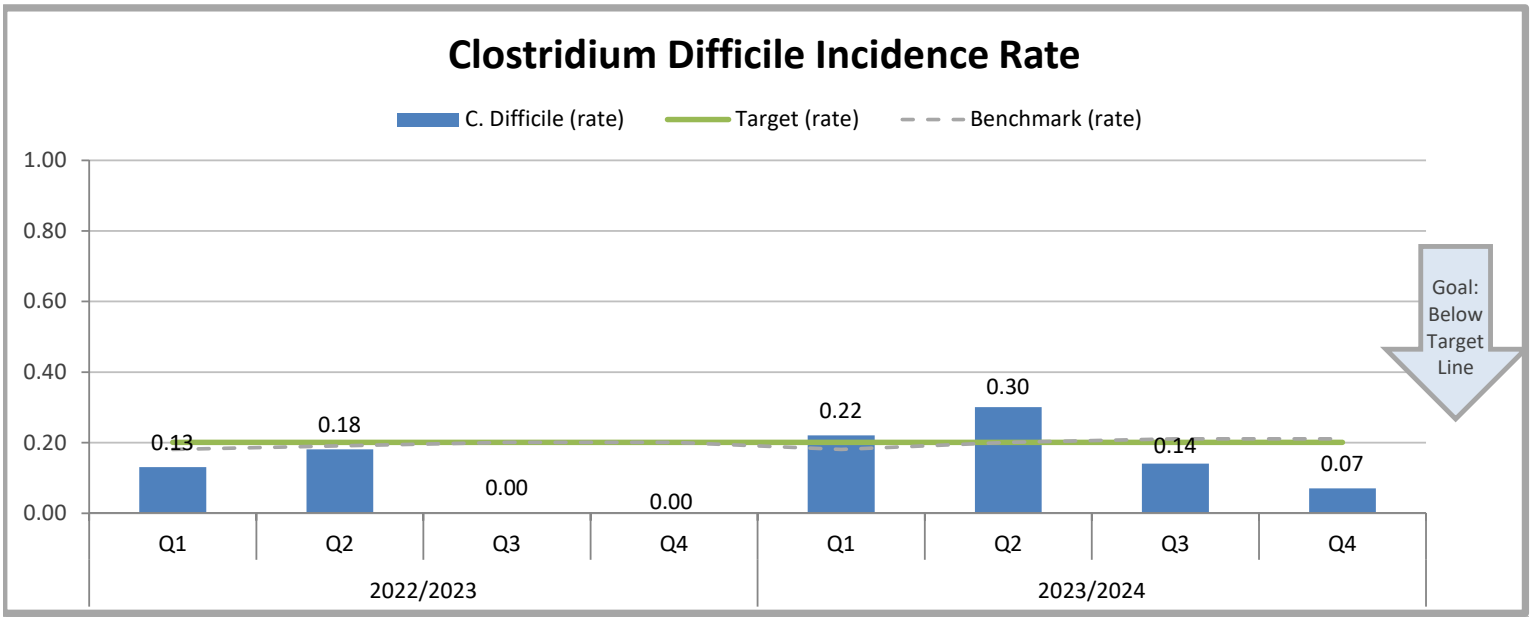
Significance: This bacteria is commonly found in the environment; it can exist in spore form and is resistant to some chemicals. It lives in approx. 3-5% of humans as normal flora and can develop if exposed to risk factors such as: prolonged antibiotic use, bowel surgery, chemotherapy and hospitalization. C Difficile is extremely transmissible.

Data Source: Infection Prevention & Control and Health Quality Ontario (HQO) -Hospital Patient Safety

Target Information: Target is based on HSAA performance standard obligations

Benchmark Information: Benchmark rates taken from HQO - Hospital Patient Safety quarterly provincial performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile (rate)	0.13	0.18	0.00	N/A	0.22	0.30	0.14	0.07
Benchmark (rate)	0.18	0.19	0.20	0.20	0.18	0.20	0.21	0.21
Target (rate)	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20



Performance Analysis:

Q1 Results unavailable due to Cyber Incident and system failure.
Q2 Results unavailable due to continued recovery and data validation.
Q3 Results for Q1 and Q2 are available and reported this quarter. Target was met for Q3.
Q4 Target met.

Plans for Improvement:

Q1 Continued focus on recovery of system. Investigating alternative methods to capture C. Diff rates.
Q2 Continued focus on recovery of system. Results for all three quarters are expected to be available by Q3.
Q3 The target was met, and we continue to monitor and evaluate.
Q4 The target was met, and we continue to monitor and evaluate.

Accountable: VP, Patient Services and Chief Nursing Officer / Manager, Infection Control

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Inpatient Bed (TIB)

Strategic Direction: RECOVERY

Definition: This is a mandatory QIP indicator. The indicator is measured in hours using the 90th percentile, which represents the time interval between the Disposition Date/Time Patient Left the Emergency Room Department for admission to an Inpatient bed or Operating Room.

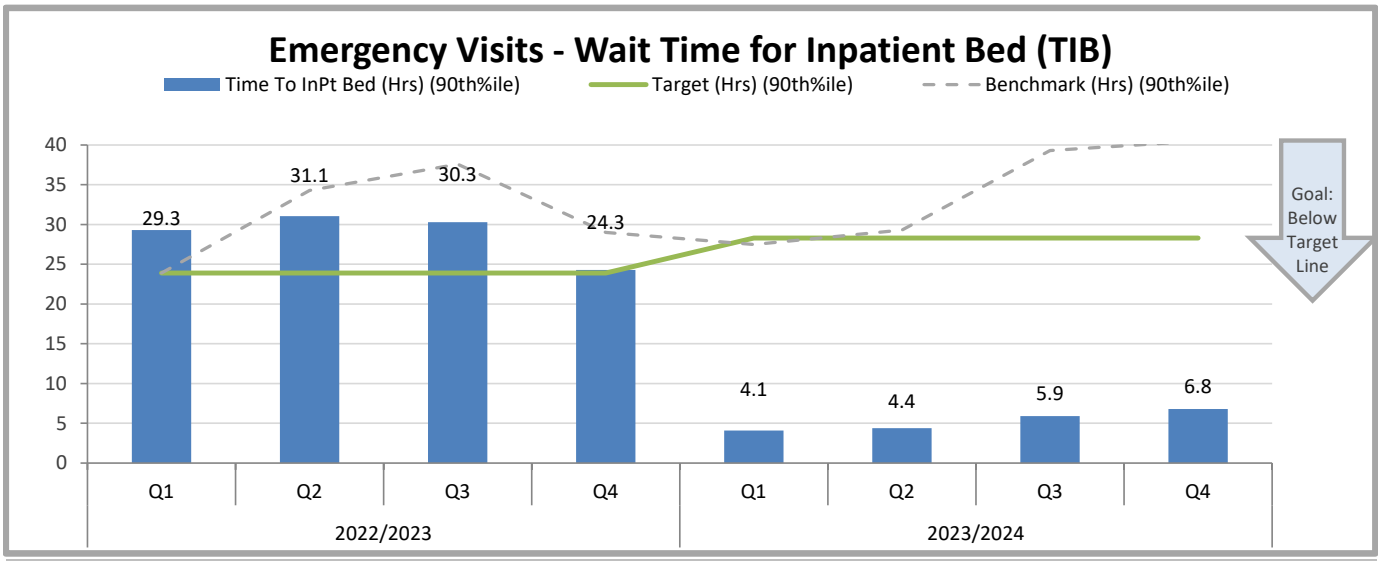
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. The 90th percentile of this indicator represents the maximum length of time that 90% of patients in the ED wait for an inpatient bed or an operating room in the ED.

Data Source: Anzer - NACRS

Target Information: Target set in accordance to QIP indicator.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	29.3	31.1	30.3	24.3	4.1	4.4	5.9	6.8
Benchmark (Hrs) (90th%ile)	23.9	34.3	37.6	29.0	27.5	29.3	39.3	40.5
Target (Hrs) (90th%ile)	23.9	23.9	23.9	23.9	28.3	28.3	28.3	28.3



Performance Analysis:

Q1 Target met. ED flow is a standing agenda item for our ED working group. ED processes are continuously monitored and recommendations for improvement are implemented by ED flow nurse.

Q2 Target met. We continue to trend within target and benchmarking peers.

Q3 Target met. Q3 had a slight increase however we continue to be within target.

Q4 Target met. Q4 had an increase compared to Q3, however remains below target.

Plans for Improvement:

Q1 The ED working group continues to analyze ED flow for potential improvements.
Continue to work closely with patient flow and Inpatient Units.
We expanded our ED flow nurse scope and increased our flow nurse coverage.
We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED.

Q2 The ED Working Group continues to analyze ED patient flow for potential improvements. We continue to work closely with Patient Flow and Inpatient Units. We maintained our Flow Nurse coverage.

Q3 The ED Working Group continues to analyze ED patient flow for potential improvements. We continue to work closely with Patient Flow and Inpatient Units. We have expanded our ED Flow Nurse coverage.

Q4 The ED Working Group continues to analyze ED patient flow for potential improvements. We continue to work closely with Patient Flow and Inpatient Units. We have expanded our ED Flow Nurse coverage. □

Accountable: Chief of Information and Operating Officer / Manager, Emergency Department

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Non-Admitted High Acuity (CTAS I-III) (Hrs) (90th Percentile)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the total time elapsed from triage or registration (whichever is earlier) to patient left ED for non-admitted high acuity (CTAS I-III) patients. Excludes CDU Length of Stay (LOS).

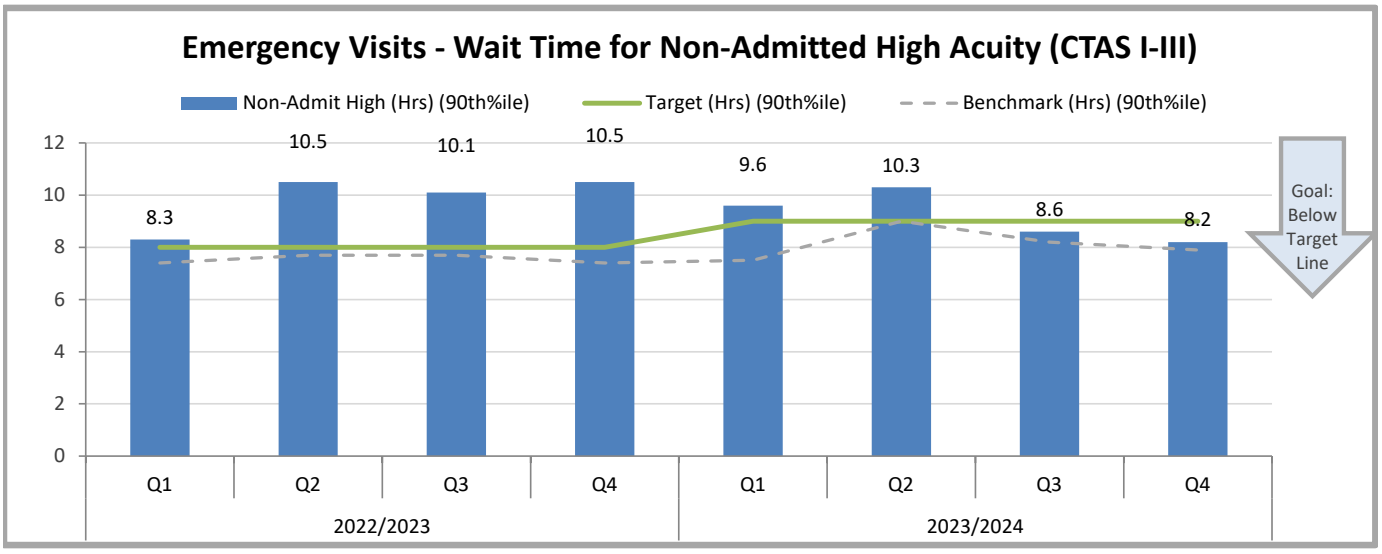
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target based on 10% improvement from prior fiscal year performance.

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group'.

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit High (Hrs) (90th%ile)	8.3	10.5	10.1	10.5	9.6	10.3	8.6	8.2
Benchmark (Hrs) (90th%ile)	7.4	7.7	7.7	7.4	7.5	9.0	8.2	7.9
Target (Hrs) (90th%ile)	8.0	8.0	8.0	8.0	9.0	9.0	9.0	9.0



Performance Analysis:

Q1 Performance continues to improve towards meeting target despite some physician coverage gaps.

Q2 Target not met. When comparing Q2 performance with Q1, CCH is showing an increase of 7%, in comparison to our peer benchmark demonstrating an increase of 20%.

Q3 Target met. For Q3 we are comparable to our benchmarking peers.

Q4 Target met. Q4 had a 4% decreased from prior quarters and continues to trend downwards.

Plans for Improvement:

Q1 We expanded our ED flow nurse scope and increased our flow nurse coverage.
We continue to utilize CDU as appropriate and increased the education and awareness surrounding CDU.
We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED.
Introduction of paramedics and ED social worker's started in their new roles within the ED.
Physician coverage expected to improve and less gaps are expected moving forward.

Q2 We maintained our ED Flow Nurse coverage. We continue to optimize the use of our ED Medical Directives to facilitate a shorter time spent in the ED. Integration of Paramedic's (Offload Specialists) and ED Social Worker's into the ED is meant to help reduce wait times. Physician coverage is expected to improve and fewer gaps are expected moving forward.

Q3 Continue with our plan from Q2, Monitor and evaluate.

Q4 Sustained improvement based on the action plan from Q2, continue to monitor, evaluate and optimize when needed.

Accountable: Chief of Information and Operating Officer / Chief of Emergency Medicine / Manager, Emergency Department

Return to Dashboard

Indicator: Emergency Visits - Wait Time for Non-Admitted Low Acuity (CTAS IV-V) (Hrs) (90th Percentile)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the total time elapsed from Triage/Registration (whichever is earlier) to patient left ED for non-admitted low acuity (CTAS IV-V) patients. Excludes CDU Length of Stay (LOS).

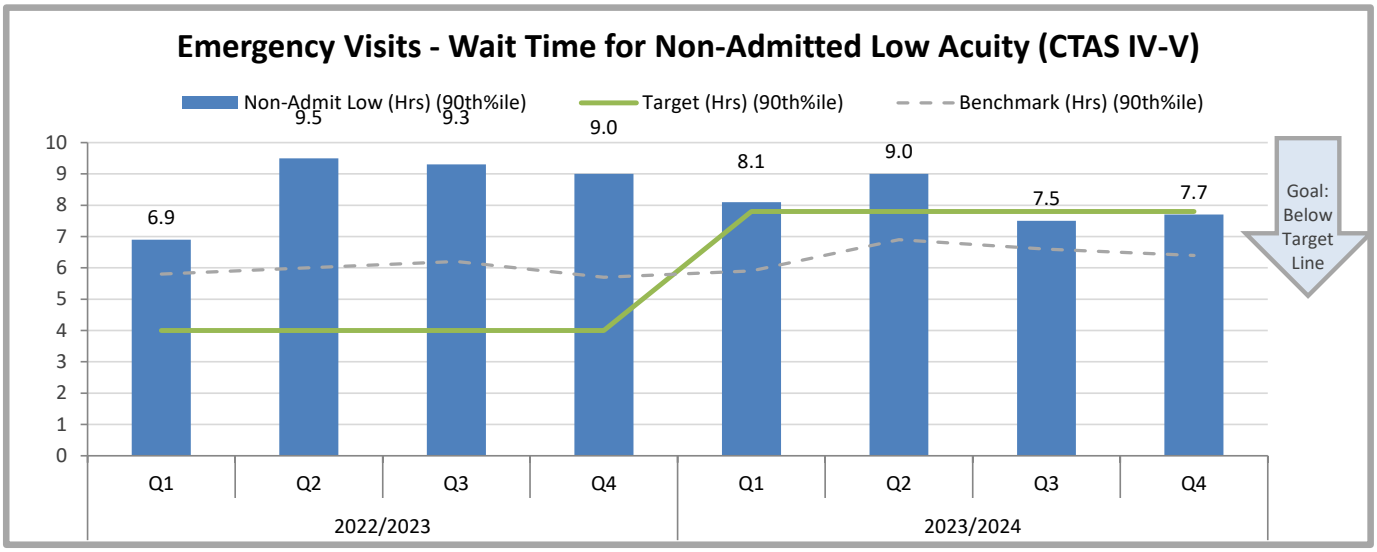
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer -NACRS

Target Information: Target based on 10% improvement from prior fiscal year performance.

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group'.

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit Low (Hrs) (90th%ile)	6.9	9.5	9.3	9.0	8.1	9.0	7.5	7.7
Benchmark (Hrs) (90th%ile)	5.8	6.0	6.2	5.7	5.9	6.9	6.6	6.4
Target (Hrs) (90th%ile)	4.0	4.0	4.0	4.0	7.8	7.8	7.8	7.8



Performance Analysis:

Q1 Performance continues to improve towards meeting target.

Q2 Target not met. Although Q2 has increased for this quarter, when comparing to same period last fiscal year, our length of stay is trending lower.

Q3 Target met. Q3 has trended downwards as we continue to improve on performance.

Q4 Target met. Q4 had a marginal increase from the previous quarter. When compared to the same period in the last fiscal year, the length of stay continues to be relatively shorter.

Plans for Improvement:

Q1 We expanded our ED flow nurse scope and increased our flow nurse coverage.
We continue to maximize our use of Medical Directives to facilitate a shorter time spent in the ED.
Introduction of paramedics and ED social worker's started in their new roles within the ED.
Physician coverage expected to improve and less gaps are expected moving forward.

Q2 We maintained our ED Flow Nurse coverage. We continue to optimize the use of our ED Medical Directives to facilitate a shorter time spent in the ED. Integration of Paramedic's (Offload Specialists) and ED Social Worker's into the ED is meant to help reduce wait times. Physician coverage is expected to improve and fewer gaps are expected moving forward. Continued to utilize CDU as appropriate.

Q3 Continue with our plan from Q2; results should continue to improve. Physician coverage has improved and is expected to be good going into next quarter.

Q4 Continue with our plan; results have improved considerably and have been sustained for 6 months now. Physician coverage has improved and is expected to be good going into next quarter.□

Accountable: Chief of Information and Operating Officer / Chief of Emergency Medicine / Manager, Emergency Department

Return to Dashboard

Indicator: Falls per 1,000 Inpatient Days

Strategic Direction: RECOVERY

Definition: The calculation is based on the total number of falls with Severity Level >=1 (no harm/damage - excluding near misses) reported and divided by the total number of patient days for all inpatient units (includes Medicine, Surgery, CCU, Women/Children, Mental Health, and Rehabilitation) per 1000 Inpatient days.

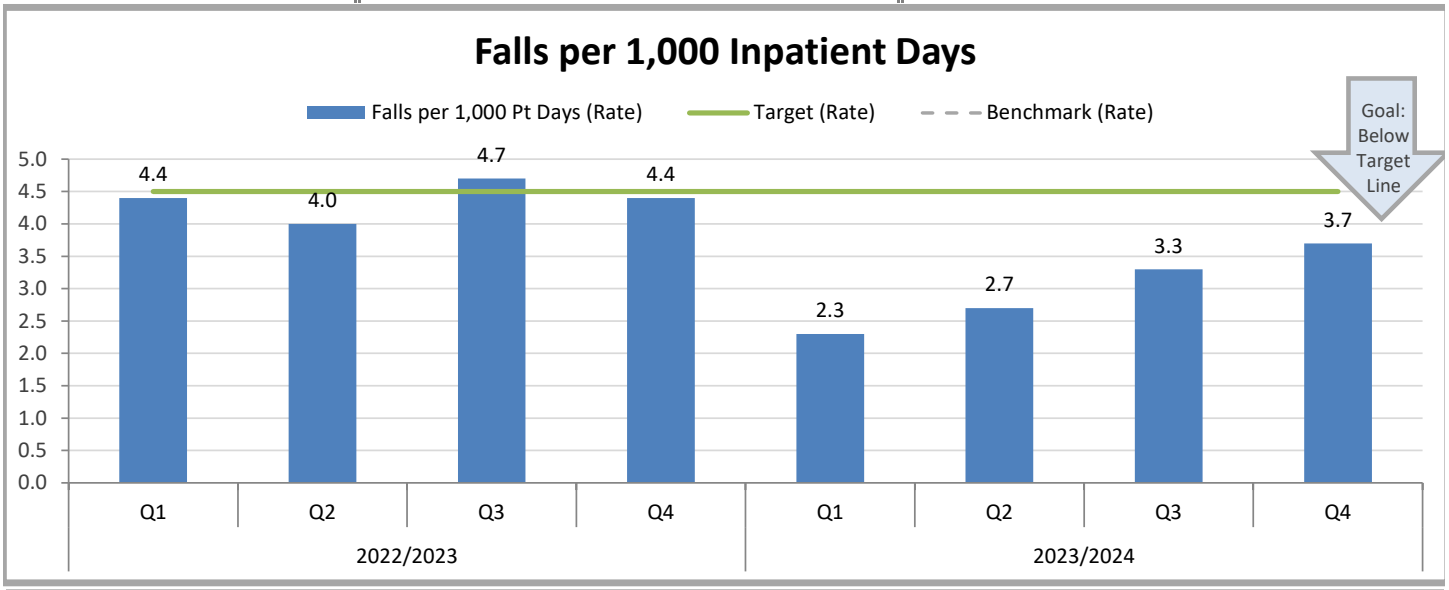
Significance: Falls, while in hospital, increase morbidity and mortality, increased length of stay, and decreased quality of life. Reducing falls indicates success in improving quality. According to Safer Healthcare Now, "A fall is defined as - An event that results in a person coming to rest inadvertently on the ground or floor or other lower level, with or without injury."

Data Source: RL Solutions; Virtuo MIS - General Ledger

Target Information: Target is based on internal directives

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Falls per 1,000 Pt Days (Rate)	4.4	4.0	4.7	4.4	2.3	2.7	3.3	3.7
Benchmark (Rate)								
Target (Rate)	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5



Performance Analysis:

Q1 Target met, however, total volumes reported for Q1 are 40% less than prior quarters potentially due the reporting system being unavailable and staff not fully using the new methods for reporting.

Q2 Target met. Fall incidences continue to be a manual process, therefore, reporting of fall incidents remain low.

Q3 Target met. Fall incidences continue to be a manual process, therefore, reporting of fall incidents remain low.

Q4 Target met. Fall incidences continue to be a manual process, therefore, reporting of fall incidents remain low.

Plans for Improvement:

Q1 Falls continue to be a priority for the Senior Friendly Committee. Recovery of RL Solution software main focus to ensure proper incident reporting.

Q2 Falls risk reduction remains a priority; auditing of falls risk processes currently underway by managers. Support/education to staff regarding manual reporting processes ongoing.

Q3 Plans as per Q2. A Mobility Working Group has been formed; the focus is on fall risk reduction/functional decline. Fall audits by managers continue.

Q4 Plans ongoing as per Q3. Electronic reporting is slated to return for FY2425 Q1. The Mobility Team continues to meet; plans of rolling out improvement strategies in Q1.

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Readmissions to Own Facility within 30-Days for Selected HIG Conditions

Strategic Direction: RECOVERY

Definition: The measuring unit of this indicator is an admission for specified chronic condition as defined by HSAA. Results are expressed as the number of select HIG (HBAM Inpatient Grouper) condition patients readmitted with same or related diagnosis within 30-days of discharge. Denominator includes total number of **indexed** discharges (for a given period) from hospital with the exclusion of records where patient had an acute transfer out, or discharge disposition is sign out or death. Overall criteria includes: select HIG conditions, Ontario resident, valid Health Care Number, and select Age.

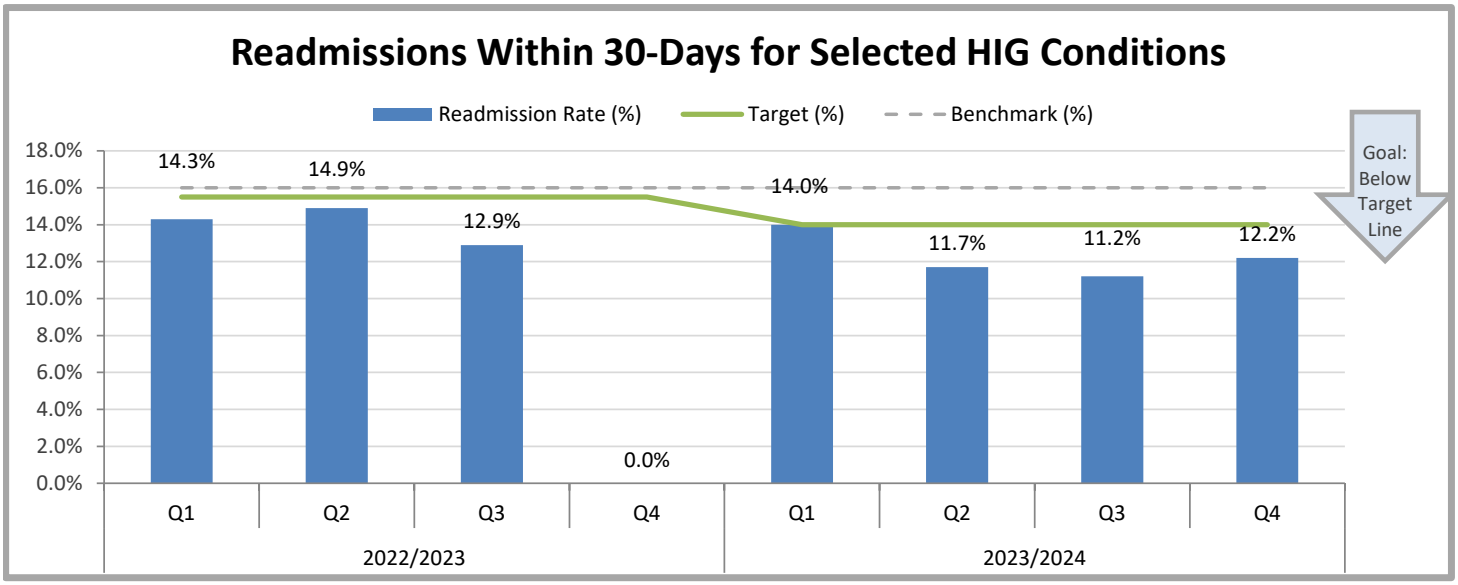
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it, this can help to reduce the number of preventable hospital readmissions. (MOHLTC - Excellent Care for All Act (2014)).

Data Source: Anzer -DAD (Discharge Abstract Database)

Target Information: Target based on 10% improvement from prior fiscal year performance.

Benchmark Information: Benchmark performance is based on our Peer Benchmark Hospitals prior year performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	14.3%	14.9%	12.9%	N/A	14.0%	11.7%	11.2%	12.2%
Benchmark (%)	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
Target (%)	15.5%	15.5%	15.5%	15.5%	14.0%	14.0%	14.0%	14.0%



Performance Analysis:

Q1 Results unavailable due to system failure (Anzer).

Q2 Results for Q1 and Q2 are available and reported this quarter. Target was met for Q1. For Q2, there were a total of 405 applicable discharges with 48 repeats within 30 days. When comparing the count for the same period prior fiscal year of 284 discharges and 66 returns, this shows a 43% increase in applicable cases discharged with select HIG.

Q3 Target met. Q3 has had significant improvement since previous quarter.

Q4 Target met. There were 469 select HIG condition visits with 57 readmissions within 30 days.

Plans for Improvement:

Q1 Anzer software has been recovered. Processes in place to recover and submit backlogged data for Q1 and Q2 reporting.

Q2 The cyber incident affected the clinical areas ability to print discharge instructions. This problem was identified and corrected in October. We continue to monitor the indicator for opportunities for improvement.

Q3 Performance within target. Will continue to work with inpatient units to print discharge instructions to reduce readmissions.

Q4 Performance within target. Will continue to work with inpatient units to print discharge instructions to reduce readmissions.

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Medicine, Rehab and Women and Children's Health

Indicator: Repeat ED Mental Health Visits

Strategic Direction: RECOVERY

Definition: The percentage of repeat emergency visits (for a mental health or substance abuse condition) following an emergency visit for a mental health condition. The repeat visit must be within 30 days of the 'index' visit (first visit). This is based on the Most Responsible Diagnosis (mental health codes - ICD-10) and includes only CCH cases.

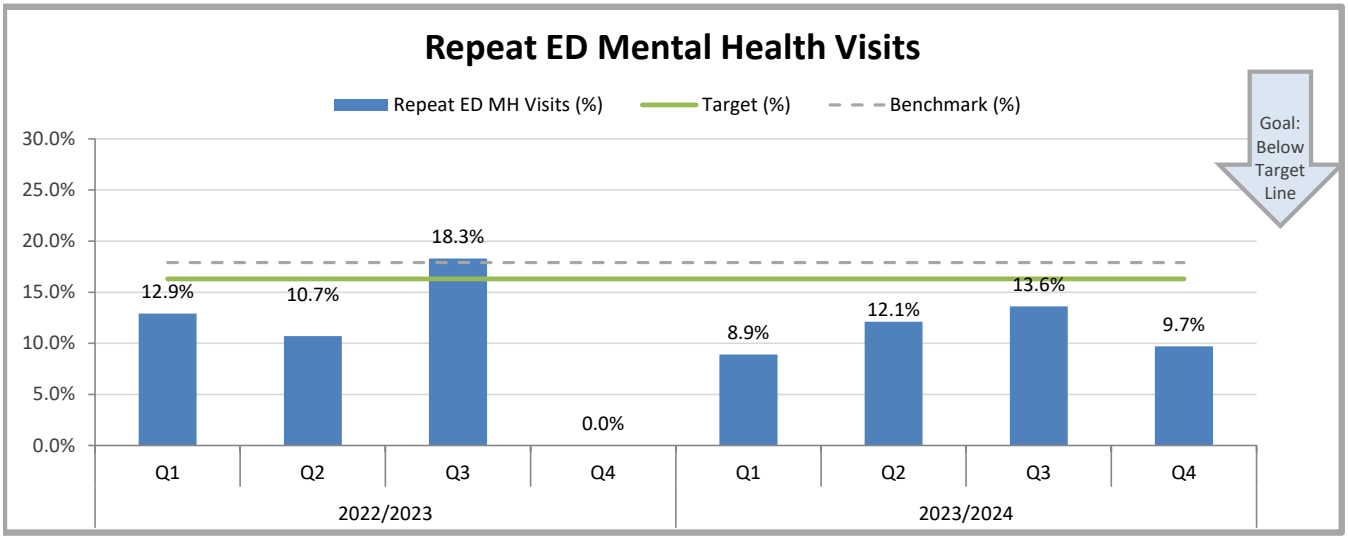
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions, access to effective community services should reduce the number of repeat unscheduled emergency visits. This indicator attempts to indirectly measure the availability and quality of community services for patients with mental health conditions. Investments in community mental health services such as crisis response and outreach, assertive community treatment teams, and intensive case management are intended to provide supports to allow individuals with mental illness to live in the community (CMHA, 2009; Every door is the right door, 2009). This indicator also supports the future development and improvement of data collected that could be used to directly measure the quality and availability of community mental health especially relating to wait times.

Data Source: Anzer - NACRS (National Ambulatory Care Reporting System)

Target Information: Target to align with 2018-2019 HSAA and MSAA

Benchmark Information: Based on Champlain LHIN 2017/18 Q2 - Appendix A results as reported in Champlain LHIN Measuring Performance Second Quarterly Report 2017-18 January 2018

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	12.9%	10.7%	18.3%	N/A	8.9%	12.1%	13.6%	9.7%
Benchmark (%)	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%	17.9%
Target (%)	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%



Performance Analysis:

Q1 Results unavailable due to Cyber Incident and system failure (Anzer).

Q2 Data available for Q1 and Q2. Q1 results show 271 ED indexed visits with 24 returns representing 8.9% and falling within suggested target. Q2 results show 265 ED indexed visits with 32 returns representing 12.1% and within suggested target.

Q3 Target met. Q3 continues to trend upwards compared to previous quarters however we continue to be below target.

Q4 Target met. Q4 had a total of 257 index visits with 25 return visist.

Plans for Improvement:

Q1 Anzer software has been recovered. Processes in place to recover and submit backlogged data for Q1 and Q2 reporting.

Q2 Performance within target. Will continue to work with ED Social Work, Inpatient Mental Health services, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits.

Q3 Will continue to work with ED Social Work, Inpatient Mental Health services, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits.

Q4 Will continue to work with ED Social Work, Inpatient Mental Health services, and Outpatient Mental Health services to maintain and improve repeat ED Mental Health visits.

Accountable: Chief of Information and Operating Officer / Manager, Emergency Department

Return to Dashboard

Indicator: Typical Average Length of Stay (ALOS) for Hospitalists

Strategic Direction: RECOVERY

Definition: The typical average length of stay for admitted inpatients, admitted under the provider service of hospitalists. Excluded patients are mental health, rehabilitation and atypical cases.

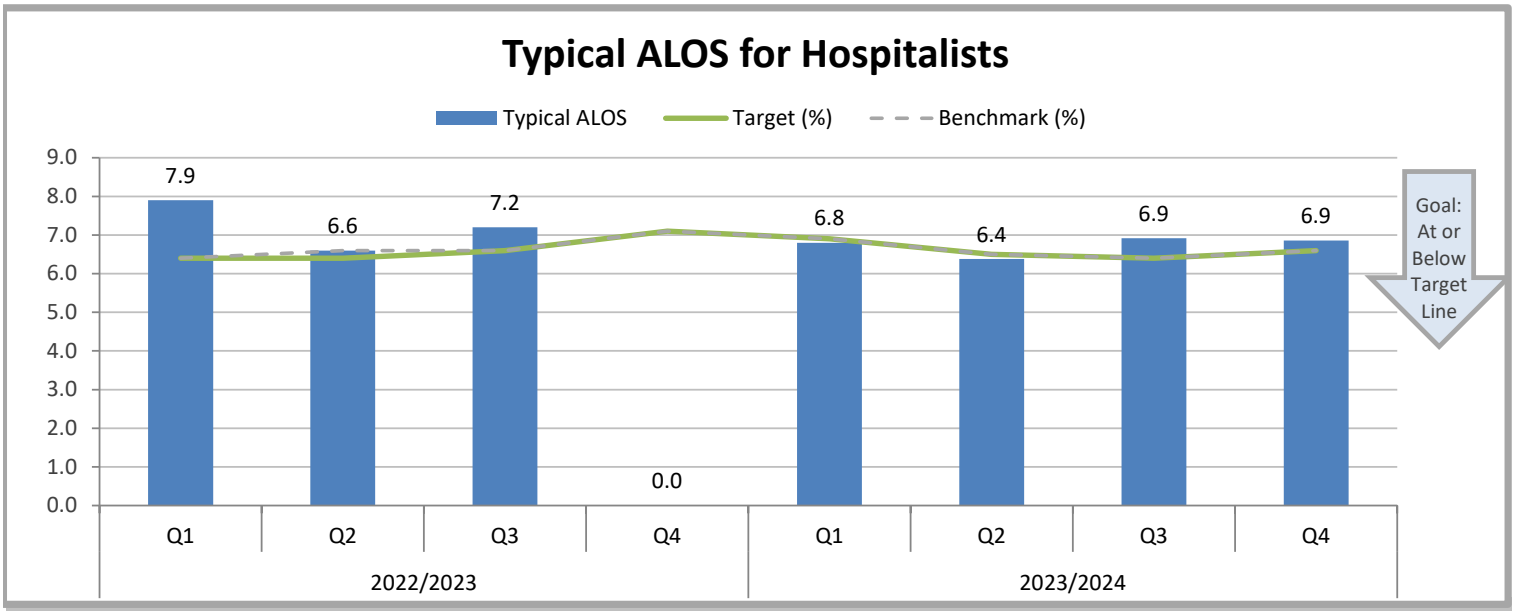
Significance: Be in more in line with our benchmark hospitals.

Data Source: CIHI Portal and Anzer -DAD (Discharge Abstract Database)

Target Information: Target based on median typical ALOS for benchmark (20) Peer Hospitals using prior quarter.

Benchmark Information: Benchmark based on median typical ALOS for benchmark (20) Peer Hospitals using prior quarter.

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Typical ALOS	7.9	6.6	7.2	N/A	6.8	6.4	6.9	6.9
Benchmark (%)	6.4	6.6	6.6	7.1	6.9	6.5	6.4	6.6
Target (%)	6.4	6.4	6.6	7.1	6.9	6.5	6.4	6.6



Performance Analysis:

Q1 Results unavailable due to Cyber Incident and system failure (Anzer).

Q2 Target met for Q1 and Q2. ALOS continue to trend downward within target and benchmarking peers.

Q3 Target not met. Target has decreased as the benchmark data is better than early in the year. However, the overall LOS (typical and Atypical) is still within target.

Q4 Target not met. The rate of Q4 has not changed, however, benchmark and target has seen a slight increase from prior quarter.

Plans for Improvement:

Q1 Anzer software has been recovered. Processes in place to recover and submit backlogged data for Q1 and Q2 reporting.

Q2 Continue to work with the Hospitalists Team Model to maintain results below target.

Q3 Continue to optimize physician coverage and timeliness discharge; The care delivery model is also being optimized by introducing additional coverage for ALC and rehab.

Q4 Continue to optimize care teams; Monitor and evaluate the new coverage model for ALC and Rehab.□

Accountable: Chief of Staff / Chief Information and Operating Officer

Return to Dashboard

Indicator: Total Margin

Strategic Direction: RECOVERY

Definition: The percentage by which total revenues exceed total expenses. A negative value indicates that expenses have exceeded revenues and a positive value indicates an excess of revenue over expenses. Performance is reported cumulatively on a year-to-date basis.

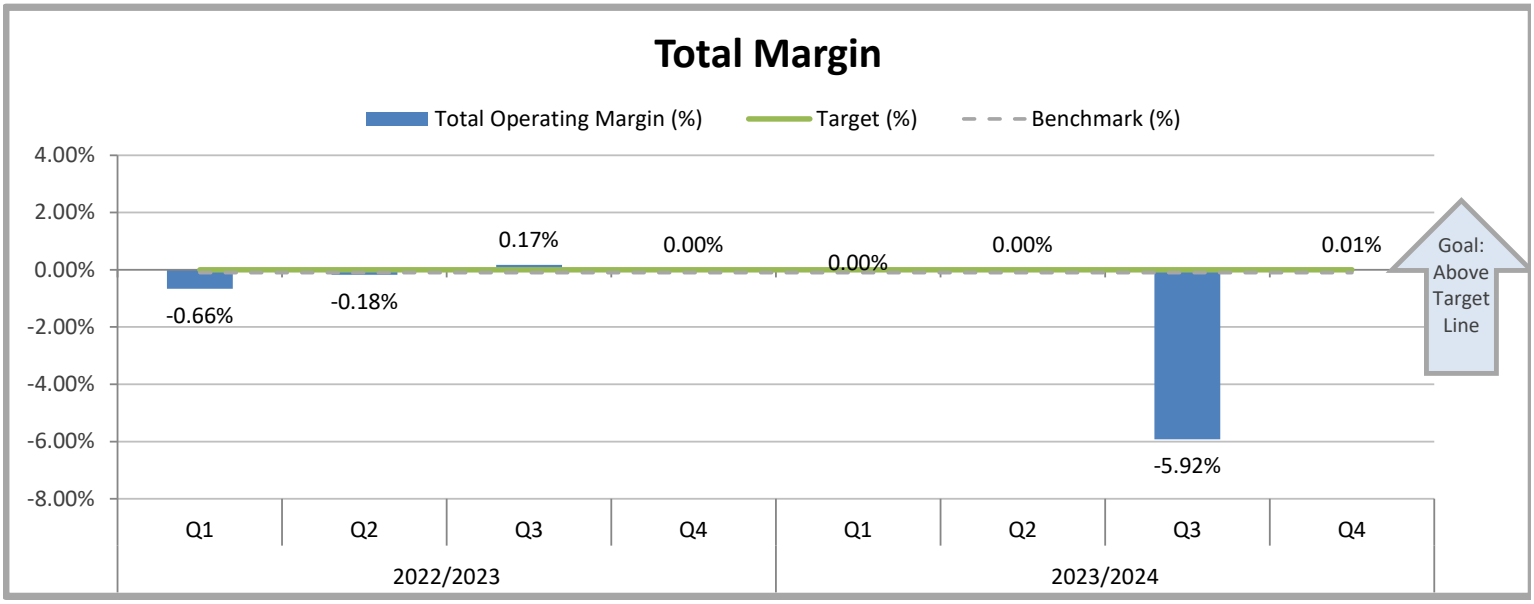
Significance: Indicates a balanced operating position.

Data Source: Monthly Financial Statements - Income Statement

Target Information: Target set according to HSAA obligations

Benchmark Information: Benchmark performance is based on prior fiscal year (Q1-Q2) Champlain LHIN Hospitals performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Total Operating Margin (%)	-0.66%	-0.18%	0.17%	N/A	N/A	N/A	-5.92%	0.01%
Benchmark (%)	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%	-0.10%
Target (%)	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%



Performance Analysis:

Q1 Results unavailable due to Cyber Incident and system failure (Virtuo).
Q2 Results unavailable due to Cyber Incident and system failure (Virtuo).
Q3 Target not met.
Q4 Target not met.

Plans for Improvement:

Q1 Continue working on system recovery and backlog.
Q2 Continue working on system recovery and backlog.
Q3 Continue to work with Ontario Health for funding to cover Bill 124 go forward impact. Q4 will meet target
Q4 Funding was received to cover Bill 124 go forward impact on a one-time basis. Advocacy work continues with OH to ensure funding is available for 2024-25.

Accountable: Chief Financial Officer / Director, Financial Services

Return to Dashboard

Indicator: Cases Completed within Target Wait Time - Computed Tomography Scans

Strategic Direction: RECOVERY

Definition: The percentage of Diagnostic Computed Tomography (CT) Scans completed within Access Target for patients >=18 years of age. Included in this measurement are those cases reported as being at Priority Level 2 (Inpatient/Urgent - Target within 48 hrs), Priority Level 3 (Cancer Staging or Restaging - Target within 10 days), or Priority Level 4 (Non-Urgent - Target within 28 days). This indicators measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted (not timed procedure).

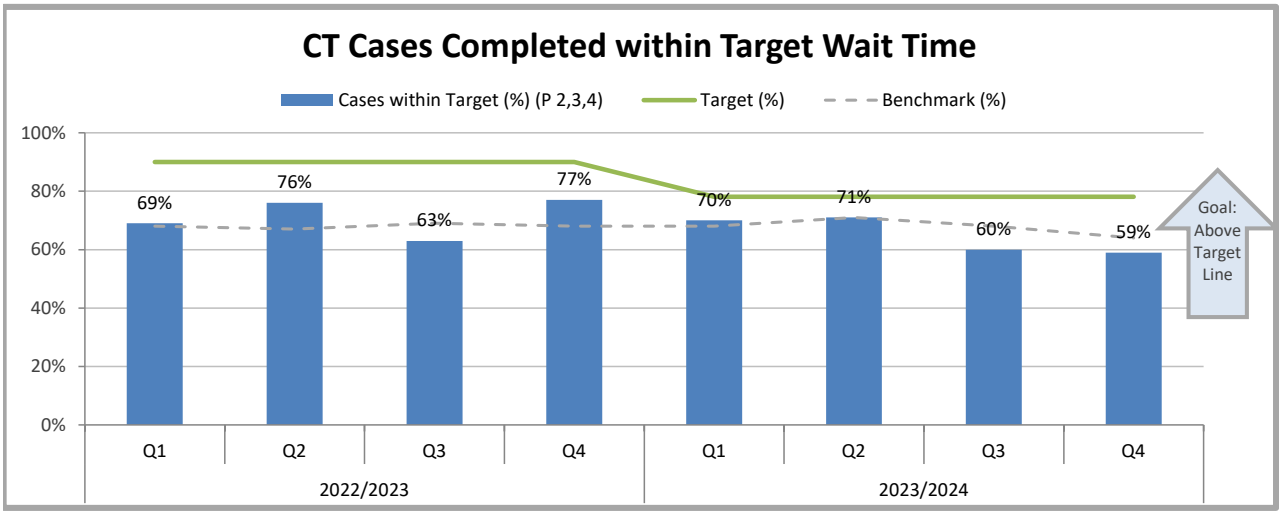
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target their resources to where they will have the most impact.

Data Source: WTIS iPort Access

Target Information: Target based on 10% improvement from prior fiscal year performance and is measured at Priority Level 2, 3, 4

Benchmark Information: Benchmark is based on iPort, Champlain LHIN quarterly performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%) (P 2,3,4)	69%	76%	63%	77%	70%	71%	60%	59%
* Priority 2	97%	98%	99%	82%	83%	80%	93%	92%
* Priority 3	97%	97%	99%	79%	70%	91%	92%	97%
Benchmark (%)	68%	67%	69%	68%	68%	71%	68%	64%
Target (%)	90%	90%	90%	90%	78%	78%	78%	78%



Performance Analysis:

Q1 Overall performance is down from Q4 of last fiscal year. However, we are hovering close to the fiscal year average. Despite encountering significant challenges, namely the cyber incident which had a tremendous impact on Diagnostic Services, we continue to maintain target for over 80% of priority 2 patients.

Q2 Overall performance for this quarter is below target, however, we continue to be comparable to our benchmarking peers. There has been significant improvement with priority level 3 as we increased 21% compared to previous quarter.

Q3 Target not met, however, we continue to be comparable to our benchmarking peers and provincial performance. Priority level 2 has shown improvement with a 13% improvement since the prior quarter.

Q4 Q4 is below target. Priority level 2 and 3 are both above target. Q4 results are within 5% of benchmark peer results.

Plans for Improvement:

Q1 We continue to focus on recruitment of registered technologists and working with HR on new strategies.
Over 80% of cases were the highest reportable priority level. We continue to balance those demands with ensuring we deliver timely care to individuals who fall within the priority 4 criteria. There are strategies being considered to support managing the wait times for lower priority cases that will allow us to deliver care in the most appropriate, equitable and efficient way possible.

Q2 Recruitment efforts remain a top priority as well as pressuring the CMRITO to consider sponsorships of international and out of province trained MRTs to address staffing shortages. Work continues on ensuring that the highest priority cases have access within targets and developing ramped up shifts with the newly developed Imaging Assistant roles to supplement the department supports. Restrictions remain in place for after hour cases from the ED to ensure we respect and retain the already stretched staffing resources.

Q3 Recruitment has been partially successful but a pending retirement will further impact performance in Q4. Same-day ED and inpatient demands have increased causing a decrease in Priority 4 availability. With increased resource availability, 24/7 or 24/5 services are being considered to allow greater focus on the non-urgent, routine studies that can be moved to the overnight, outpatient services.

Q4 24/7 coverage has started, it is being evaluated and monitored in terms of results and staff satisfaction. New recruits to start next month. Many of the cases in the queue have been completed and results should be much better starting next quarter.

Accountable: Chief Information and Operating Officer / Director, Diagnostic Services

Indicator: Cases of Long Waiters Exceeding Targeted Wait Times

Strategic Direction: RECOVERY

Definition: The percentage of Long Waiters whose total number of days waiting for their surgical procedure has exceeded the associated Priority Level Access Target. Included in this measurement are Pediatric and Adult Elective cases reported as being at Priority Level 2 (Inpatient/Urgent), Level 3 (Semi-Urgent), or Level 4 (Non-Urgent).

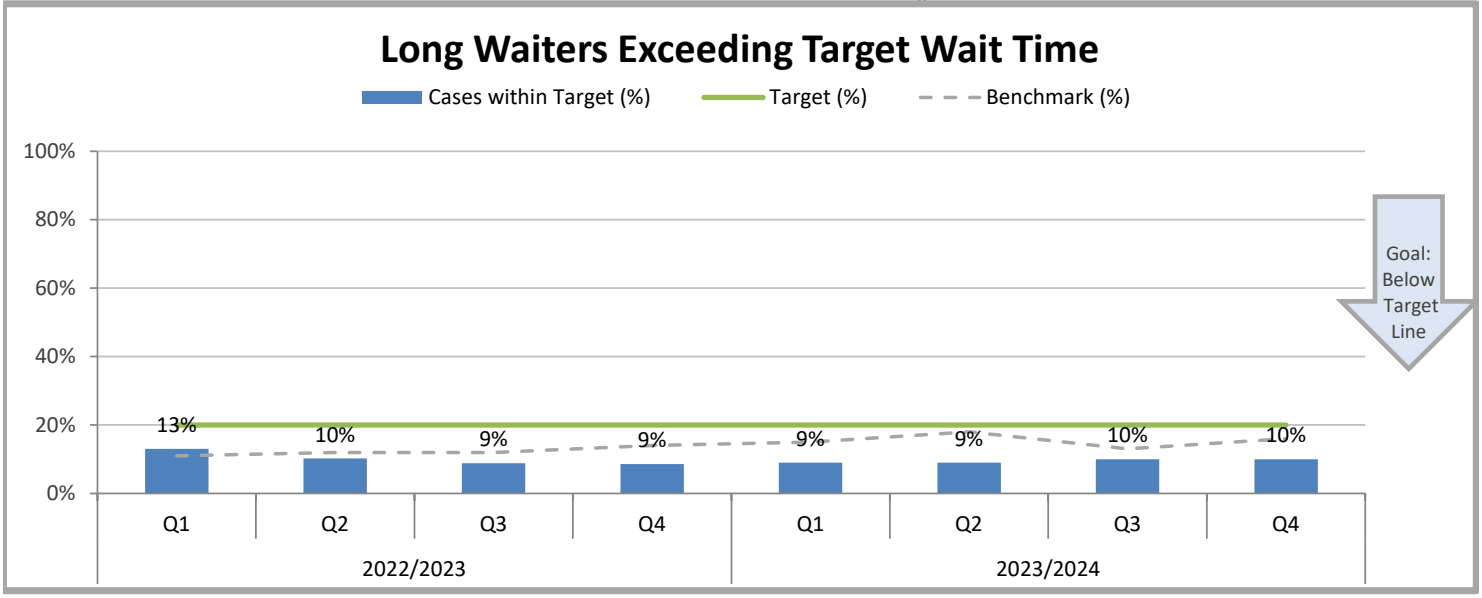
Significance: New HSAA indicator identified to decrease the volume of long waiters. Patients whose surgeries have been delayed longer than their maximum clinical guidelines are considered long waiters. The Ministry Surgical Recovery Programs are targeted at reducing the number of long waiter patients from current levels. According to a recent report by the Fraser Institute on Access to Healthcare in Canada, long wait times are more than a "benign inconvenience", they can lead patients with serious consequences, such as increase pain and suffering, mental health anguish and long-term risks.

Data Source: WTIS iPort Access

Target Information: Target is based on HSAA obligations and is measured at Priority Level 2, 3, 4

Benchmark Information: Benchmark is based on iPort, Champlain LHIN quarterly performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	13%	10%	9%	9%	9%	9%	10%	10%
Benchmark (%)	11%	12%	12%	14%	15%	18%	13%	16%
Target (%)	20%	20%	20%	20%	20%	20%	20%	20%



Performance Analysis:

Q1 Target met at all priority levels (P2 8.6%, P3 8.8% and P4 8.7%).
Q2 Target met. Q2 results, continues to remain within target in all priority levels.
Q3 Target met. All priority levels are within target (P2 10%, P3 8%, P4 11%).
Q4 Target met. Q4 results continue to remain within target in all priority levels.

Plans for Improvement:

Q1 We continue to look at utilization within the OR and monitor the long waiters to remind offices to book these patients and prioritize their bookings. Upcoming education session with the offices to review WTIS and the need for accurate input of information into Novari.
Q2 Continue to monitor long waiters and notify phyisician offices.
Q3 Continue to monitor long waiters and notify phyisician offices.
Q4 Continue to monitor long waiters and notify phyisician offices.

Accountable: VP, Patient Services and Chief Nursing Officer / Chief of Surgery / Director, Perioperative Services and Inpatient Surgery

Return to Dashboard

Indicator: Cases Completed within Target Wait Time - Magnetic Resonance Imaging Scans

Strategic Direction: RECOVERY

Definition: The percentage of Diagnostic Magnetic Resonance Imaging (MRI) Scans completed within Access Target for patients >=18 years of age. Included in this measurement are those case reported as being at Priority Level 2 (Inpatient/Urgent - Target within 48 hrs), Priority Level 3 (Cancer Staging or Restaging - Target within 10 days), or Priority Level 4 (Non-Urgent - Target within 28 days). This indicators measures the wait time from when a diagnostic scan is ordered, until the time the actual exam is conducted (not timed procedure).

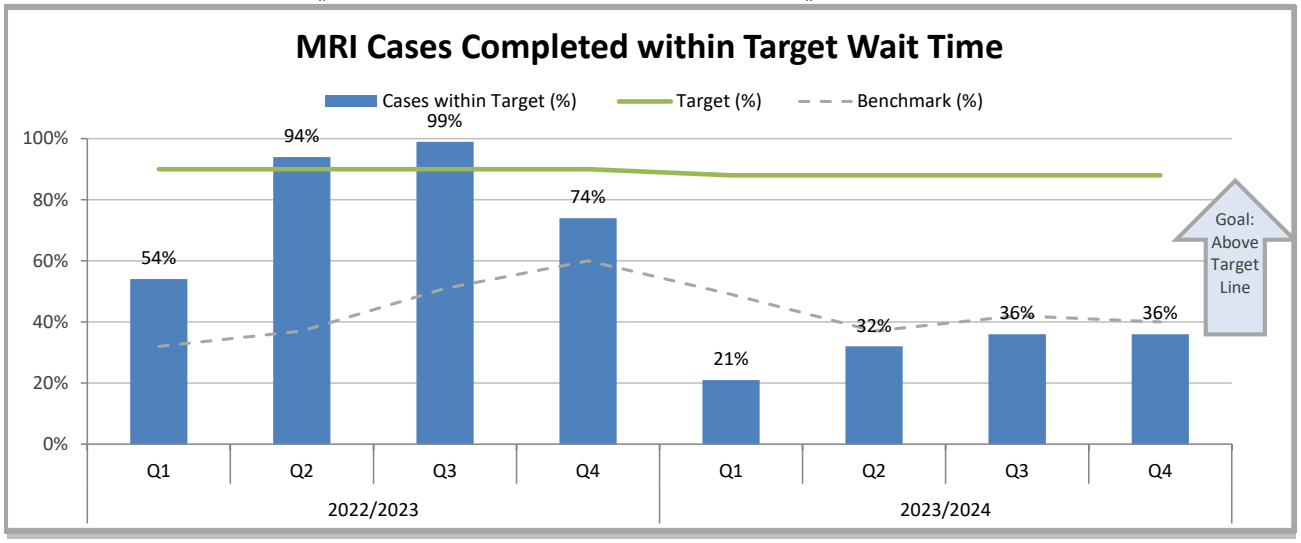
Significance: The Ontario government is implementing a plan to increase access and reduce wait times for five major health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, as well as MRI and CT exams. This will help hospitals and the government to better target their resources to where they will have the most impact.

Data Source: WTIS iPort Access

Target Information: Target based on 10% improvement from prior fiscal year performance and is measured at Priority Level 2, 3, 4

Benchmark Information: Benchmark is based on iPort, Champlain LHIN quarterly performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cases within Target (%)	54%	94%	99%	74%	21%	32%	36%	36%
* Priority 2	100%	96%	98%	100%	88%	97%	98%	99%
* Priority 3	100%	94%	98%	96%	57%	97%	99%	97%
Benchmark (%)	32%	37%	51%	60%	49%	37%	42%	40%
Target (%)	90%	90%	90%	90%	88%	88%	88%	88%



Performance Analysis:

Q1 During Q1, 86.8% of MRI cases were priority 4. Many of these cases were already past target turnaround times. This is due to the continuing recovery efforts as well as being nearly completely shut down for a duration of time in Q1 as a result of the cyber incident. Because so many individual cases were past target dates, we see the significant impact in our overall performance.

Q2 Q2 is below target, however, priority level 2 and 3 are both above target at 97%. Priority level 4 was 16% which is the contributing factor to the low performance for Q2.

Q3 Q3 continues to be below target. Priority level 4 was 15% which is the contributing factor for the low performance for Q3. Although well below target, CCH is in keeping with some regional peers of Champlain.

Q4 Q4 is below target. Priority level 2 and 3 are both above target. Q4 results are within 5% of benchmark peer results.

Plans for Improvement:

Q1 It is important to note that we continue to work on recovery. Part of this is ensuring that priority 4 cases are completed, despite being past the target times. The highest reportable priority level (priority 2) cases had 88% completed within target. This is a remarkable feat given the challenges faced by this team during Q1.
Recruitment efforts continue to be a top priority for the department, as staffing will be the limiting factor for being able to fully recover the backlog cases.

Q2 Recruitment remains a top priority with an actively engaged recruitment hunter firm. Although performance indicates access is consistent for the highest priority patients, the metric will be limited on further improvement until the staffing situation improves. Focus is on maximizing the booking schedule for efficiency, balanced with retention and protection of the department that is reduced by 50%.

Q3 Recruitment has been partially successful by acquiring an MRT for one of the two vacant full-time positions. The effective start date aligns with the new fiscal year, given the candidate is relocating to Cornwall.
Long-term planning includes exploring the utilization of the surgical transition fund to uptrain two techs from the department to become MRI techs (Starting Sep 2024).

Q4 Due to current staffing, the focus in Q4 and into Q1 will continue to be Priority 2 and Priority 3. Expectation is with new recruits starting in June that the queue will start to shrink and improvements are expected to start in Q2 of next year.

Accountable: Chief Information and Operating Officer / Director, Diagnostic Services

Return to Dashboard

Indicator: Alternate Level of Care (ALC) Throughput

Strategic Direction: INTEGRATION

Definition: ALC Throughput represents the flow of patients designated and discharged by using the ratio of the number of discharged ALC cases to the number of newly added ALC cases with a specific period of time (Excludes: Discontinued cases and ALC cases of 0 days).

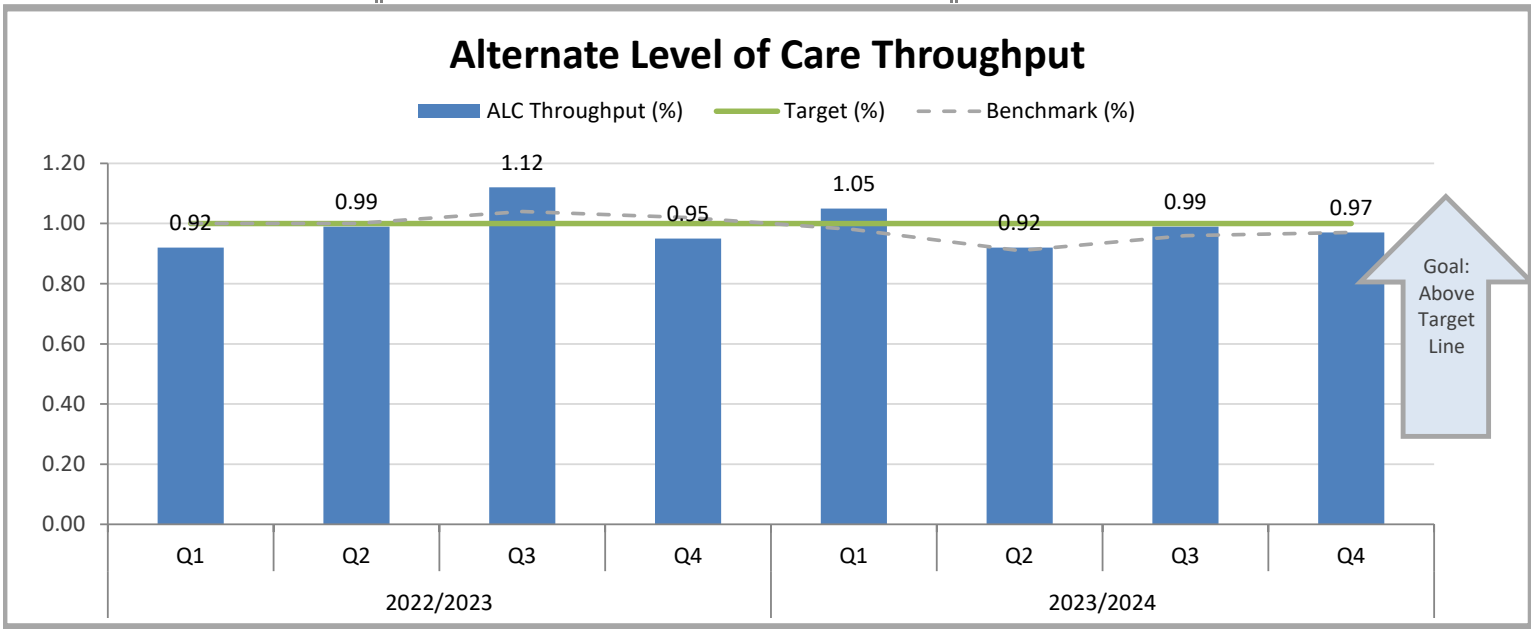
Significance: Cornwall Community Hospital will continue to identify and implement additional strategies with Champlain health care providers to reduce alternate level of care days.

Data Source: ATC CCO ALC Throughput Report

Target Information: Target rate is standardized according to HSAA specifications

Benchmark Information: Benchmark performance is based on ATC iPort - Champlain LHIN quarterly performance

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ALC Throughput (%)	0.92	0.99	1.12	0.95	1.05	0.92	0.99	0.97
Benchmark (%)	1.00	1.00	1.04	1.02	0.98	0.91	0.96	0.97
Target (%)	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00



Performance Analysis:

Q1 New indicator. Target met.

Q2 Target not met. There were 8 ALC designated cases that exceeded the total volume of ALC discharges (146 discharges/154 designated).

Q3 Target not met. There was only 1 ALC designated case that exceeded the total volume of ALC dishcarges (168 discharges/169 desginated).

Q4 Target not met. 6 ALC designated cases exceeded the total volume of ALC discharges (184 discharges/190 designated).

Plans for Improvement:

Q1 Continue to leverage early discharge planning and patient flow coordination to ensure ALC cases are discharged in a timely fashion.

Q2 CCH participated in the provincial ALC Self-Assessment. Improvement strategies underway (environment, staff education, standard work) that align with ALC reduction. Focus will be on decreasing risk of ALC as well as management of responsive behaviors and functional decline.

Q3 ALC reduction remains a priority; ALC reduction strategies include behavioral support initiatives, the Mobility Working group, CCH @Home Program, etc…

Q4 Plans as per Q3. CCH will be participating in a regional Long-Stay panel which reviews long-stay challenges and reduction strategies.

Accountable: Director, Subacute Medicine / Manager, Patient Flow and Bed Management

Return to Dashboard

Indicator: Discharge Summary Sent from Hospital to Primary Care Provider Within 48 Hours of Discharge

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their primary care provider (PCP) within 48 hours of patient's discharge from hospital.

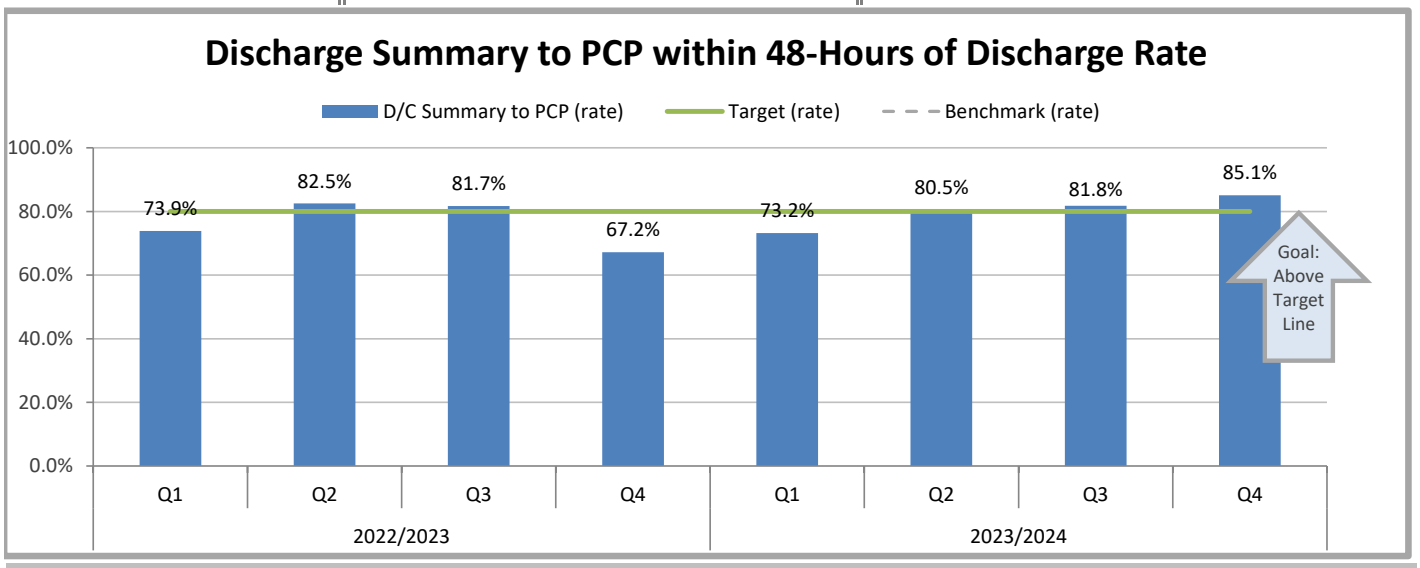
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete or inaccurate transfer of information, lack of comprehensive follow-up care, and/or medication errors at the time of transition could be very dangerous and cause serious, preventable harm to patients. Furthermore, the impact of these risks may be intensified by patients and families who feel unprepared for self-management, and are unsure of how to access appropriate health care providers for follow-up."

Data Source: Cerner - Discern Analytics, Electronic Health Record

Target Information: Target is set internally at 80.0% in accordance to QIP indicator

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	73.9%	82.5%	81.7%	67.2%	73.2%	80.5%	81.8%	85.1%
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Target not met. Lack of VPN access may contributed to the performance level.
There were a total of 1339 applicable discharges with 980 completed within 48 hours.

Q2 Target met. There were a total of 1291 applicable discharges with 1039 completed within 48 hours.

Q3 Target met. Q3 had a total of 1294 applicable discharges with 1059 completed within 48 hours. Q3 continues to trend upwards.

Q4 Target met. Q4 had a total of 1366 applicable discharges with 1163 completed within 48 hours.

Plans for Improvement:

Q1 Encourage physicians to complete their mandatory documentation within 48-hours while on site until VPN access is available.
Working to reestablish remote access (started first week of September).
Working towards introduction of a new tool (Power Chart Touch) which should allow physicians to complete their documentation remotely in a very convenient way. Expected to go live Q3.

Q2 VPN has been reestablished for most physicians. Continue to monitor and encourage physicians to complete their mandatory documentation within 48 hours.

Q3 Powerchart Touch (Cerner mobile app) is live for physicians; we will be evaluating its utilization for documentation purposes and the impact on this metric.
HIS will continue to email physicians daily who have outstanding discharge summaries that are within 48 hours of discharge.

Q4 We continue to work with Health Information Services to monitor and reach out to physicians who need to complete any outstanding discharge summaries.

Accountable: Chief Information and Operating Officer / Medical Affairs

Return to Dashboard

Indicator: Incomplete Charts

Strategic Direction: INTEGRATION

Definition: This measures incomplete charts at thirty days after discharge. It is a snapshot of the incomplete (deficient and signatures) charts. Report is generated on the last business day of each quarter.

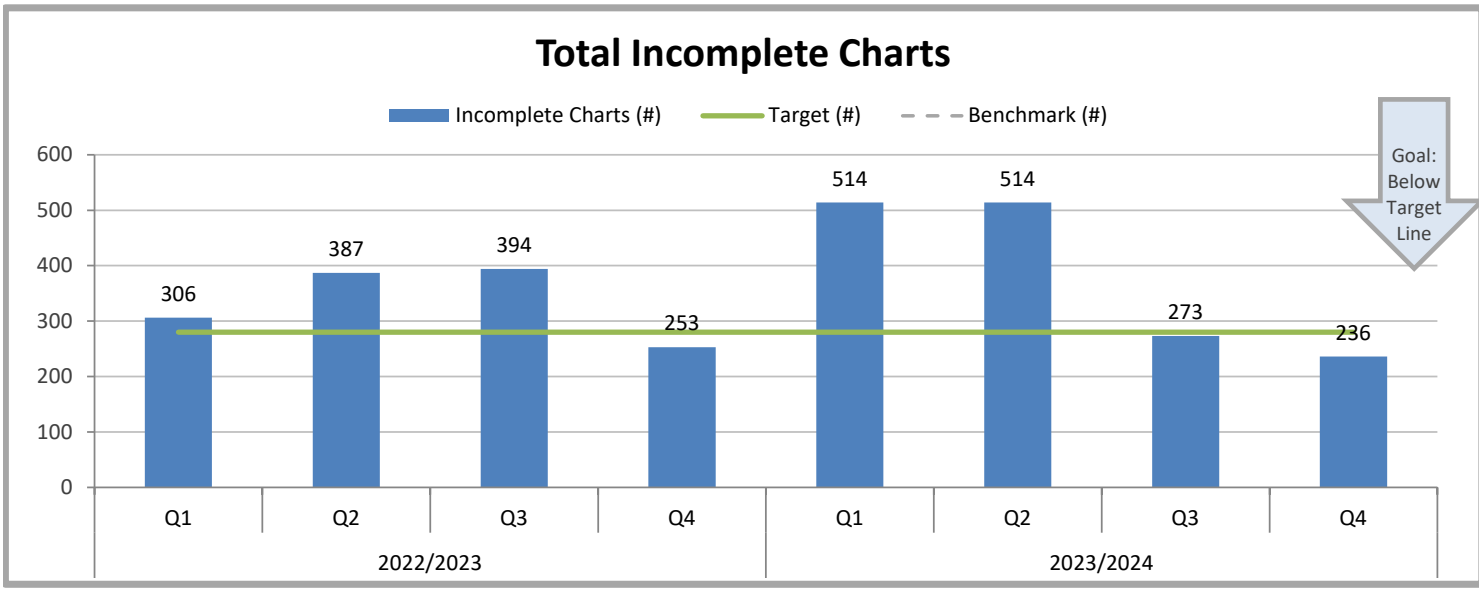
Significance: The purpose of this policy is to ensure that patient health records are completed in accordance with legal requirements, including the Public Hospitals Act (PHA) and Hospital Management Regulation 965 (Regulation), professional obligations, as well Hospital by-Laws, policies, rules and procedures. Record completion is necessary for continuity of patient care, to support a collaborative care services delivery model and for the protection of the individual practitioner from potential liability.

Data Source: Cerner - Discern Analytics (Incomplete Chart Report)

Target Information: Continue with prior year target.

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incomplete Charts (#)	306	387	394	253	514	514	273	236
Benchmark (#)								
Target (#)	280	280	280	280	280	280	280	280



Performance Analysis:

Q1 Target not met. Due to the cyber incident, VPN was not available to physicians for chart completion off site.

Q2 Target not met.

Q3 Target met. Q3 had a 46% decrease in completed charts compared to prior quarter.

Q4 Target met. Q4 decreased 14% in completed charts compared to prior quarter.

Plans for Improvement:

Q1 VPN access for physicians is being restored and is expected to have a positive impact going forward.
Working towards introduction of a new tool (Power Chart Touch) which should allow physicians to complete their documentation remotely in a very convenient way.

Q2 VPN access has been reintroduced for physicians. Power Chart Touch tool has been developed and will be rolled out Q3. Significant improvement on this metric is expected and target should be met by Q4.

Q3 Target met. Monitoring to continue.

Q4 Target met. Monitoring to continue.

Accountable: President and Chief Executive Officer / Chief of Staff

Return to Dashboard

Indicator: Medication Scanning Compliance

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of medication administered for which a medication scan was completed for all inpatient and emergency department patients (Excludes Outpatient, Day Surgery, Ambulatory Care).

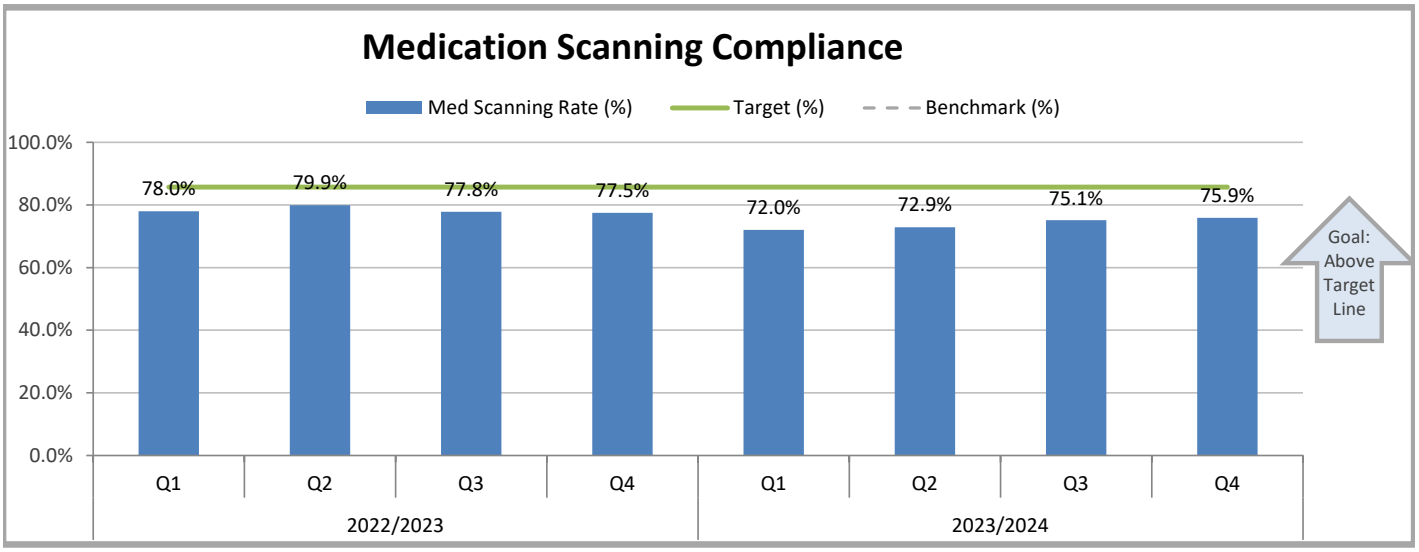
Significance: Barcode medication administration (BCMA) systems scan a patient's wristband and medication to be given in order to prevent medication errors. BCMA has shown to reduce medication administration errors significantly and to reduce harm from serious medication errors.

Data Source: Cerner Reporting Portal

Target Information: Set internally at 85.7% in accordance to QIP indicator

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Scanning Rate (%)	78.0%	79.9%	77.8%	77.5%	72.0%	72.9%	75.1%	75.9%
Benchmark (%)								
Target (%)	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%



Performance Analysis:

Q1 Target not met. Gathering additional data for analysis of performance.

Q2 Target not met. All locations fall below target.

Q3 Target not met. All nursing units continue to fall below target, however, the compliance rate continues to move in the right direction.

Q4 Target not met. Majority of nursing units continue to fall below target, however, the Q4 rate continues to increase from prior quarters.

Plans for Improvement:

Q1 In Q1 evaluation of medication scanning override options based on best practices was completed and approved; education to follow. Technology assessment currently underway to ensure no operational gaps. Plan to engage end users through CI Council in Q2 to further understand gaps in compliance.

Q2 In Q2, environmental scan of medication administration locations was completed and plan was put in place to ensure medication scanners are available in locations with current gaps. Continue to educate on reporting medication scanning issues. Plan to continue to engage end users through huddles to further understand continued gaps in compliance. Will highlight importance of closed loop medication in Q3 through CI Newsletter.

Q3 In Q3, the importance of medication scanning in relation to patient safety was presented to clinical leadership. An infographic was developed and distributed re: medication scanning and patient safety implications; clinical managers were requested to huddle with staff to review. Work is being completed to improve communication between pharmacy and CI when new products are received/barcodes change to ensure products are updated prior to being distributed to the clinical units.

Q4 In Q4, the CI and pharmacy teams completed testing and determined that vendor barcodes had been updated to include lot and expiry numbers. Oracle Cerner was engaged, and a new workflow for these updated barcodes will be tested by the end of May.

Accountable: Professional Practice/Quality & Risk Management

Return to Dashboard

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

Strategic Direction: INTEGRATION

Definition: This is a priority indicator; medication reconciliation at care transition has been recognized as best practice, and is an Accreditation Required Organization Practice. Total number of discharged patients with completed Medication Reconciliation divided by the total # of discharged patients. (Excludes - Interfacility Transfers, Deaths, ED Hold, PACU, Obstetrical and Newborn patients).

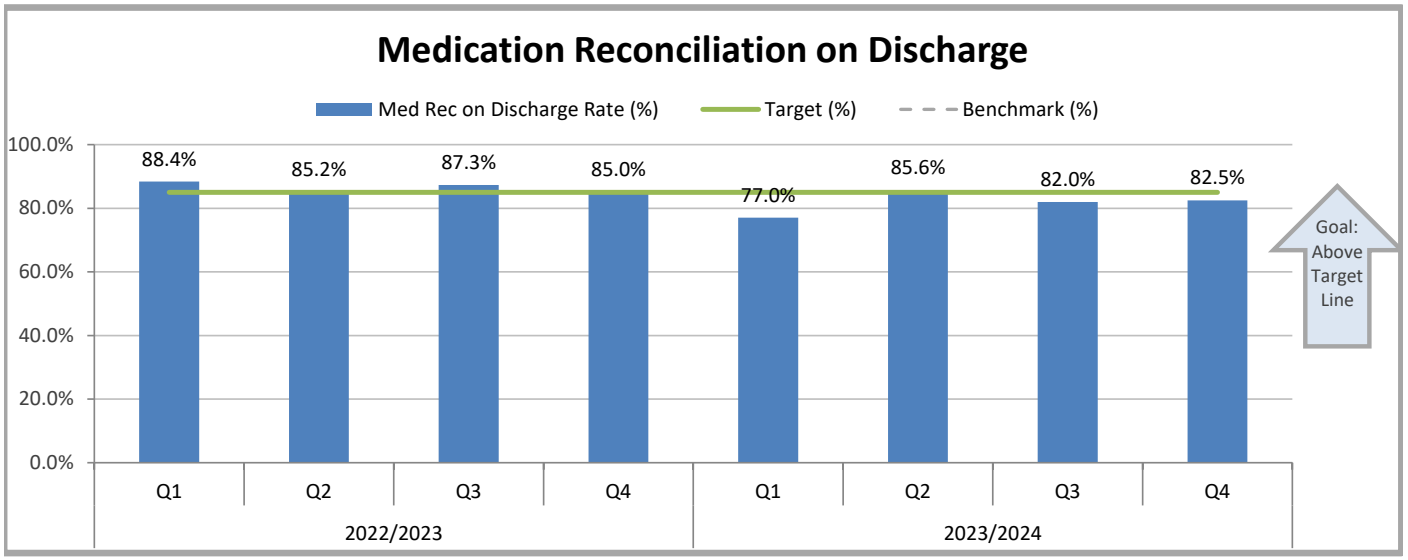
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a systematic and comprehensive review of all the medications a patient is taking to ensure that medications being added, changed or discontinued are carefully evaluated. It is a component of medication management and will inform and enable prescribers to make the most appropriate prescribing decisions for the patient (Safer Healthcare Now! Medication Reconciliation in Acute Care Toolkit, Sept 2011).

Data Source: Cerner electronic health record

Target Information: Set internally at 85% in accordance to QIP indicator

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	88.4%	85.2%	87.3%	85.0%	77.0%	85.6%	82.0%	82.5%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met this quarter due to the impact of the Cyber Incident on April results. Although results are 10% lower than prior quarters, the monthly results for Q1 are trending in the right direction showing Apr, May, June results of 62.7%, 81.0%, 85.3% retrospectively.

Q2 Target met overall. All locations within target, except for Level 6 WCH (70%) and Level 2 Surgery (78%).

Q3 Target not met. Monthly results are within 5% of meeting target and trending upwards each month.

Q4 Target not met. Majority of units are within target. Level 6 South (46.5%) and Level 6 WCH Peds (5.9%) are a contributing factor to target not being met.

Plans for Improvement:

Q1 Inpatient Surgery and WCH are the two focus areas this quarter. Inpatient Surgery Manager will discuss the unit's med rec on discharge rate at the OR committee scheduled September 12th, 2023. As well, this will be brought forward to Chief of Surgery in hopes to identify opportunities with the group. Both Inpatient Surgery and WCH will examine the data of incomplete med recs at discharge to identify trends and opportunities.

Q2 In Q2, both Level 2 Surgery and Level 6 WCH remain below target this quarter. To continue working with units below target to educate on importance with appropriately completing Med Rec at Discharge. Plan to continue engaging MRPs through meetings and discussions to further understand ongoing gaps in compliance and identify improvement strategies for the next quarter.

Q3 For units that fall below target, department chiefs are provided Med Rec on Discharge to identify opportunities and barriers with completion.

Q4 Continue to work with departments where performance falls below target. Department chiefs are provided Med Rec on Discharge to identify opportunities and barriers with completion. □

Accountable: Chief Information and Operating Officer / Chief of Staff

Return to Dashboard

Indicator: Complaints Acknowledged Within Five (5) Business Days

Strategic Direction: PEOPLE

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

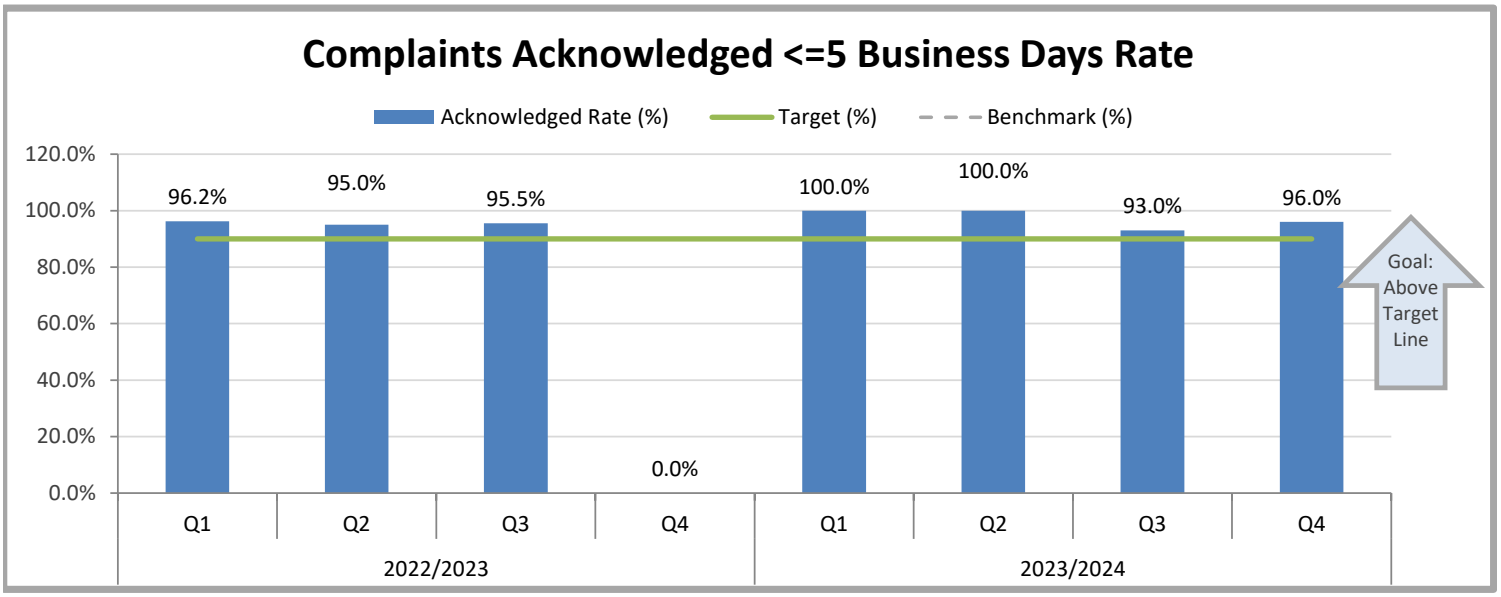
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within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

Data Source: RL Solutions

Target Information: Target is set internally at 90.0%

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)	96.2%	95.0%	95.5%	N/A	100.0%	100.0%	93.0%	96.0%
Benchmark (%)								
Target (%)	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%



Performance Analysis:

Q1 Target met. Workaround in place due to lack of RL Solution. There were a total of 31 complaints acknowledged within 5-days out of 31 total complaints for Q1.

Q2 Target met. There were a total of 32 complaints acknowledged within 5-days out of 32 total complaints for Q2.

Q3 Target met. There were a total of 40 complaints acknowledged within 5-days out of 43 total complaints for Q3.

Q4 Target met. There were a total of 48 complaints acknowledged within 5-days out of 50 total complaints for Q4.

Plans for Improvement:

Q1 Continue monitoring performance and recovery of RL Solution.

Q2 Continue monitoring performance and recovery of RL Solution.

Q3 Continue monitoring performance. Recovery of RL underway.

Q4 Target exceeded this quarter. Annual performance was 96.8%. Continue to work toward 100% acknowledgement within 5 business days. RLDatix Incident Reporting System scheduled to go-live mid-June. This will improve access to complaints in order to ensure acknowledgement within the targeted timeframe.

Accountable: VP, Patient Services and Chief Nursing Officer

Return to Dashboard

Indicator: Indigenous Cultural Awareness

Strategic Direction: PEOPLE

Definition: The percentage of people (including staff, students, physicians, and volunteers) who participated in Indigenous training over the total number of people. Denominator is set at 1,000 people. Performance is cumulative year-to-date.

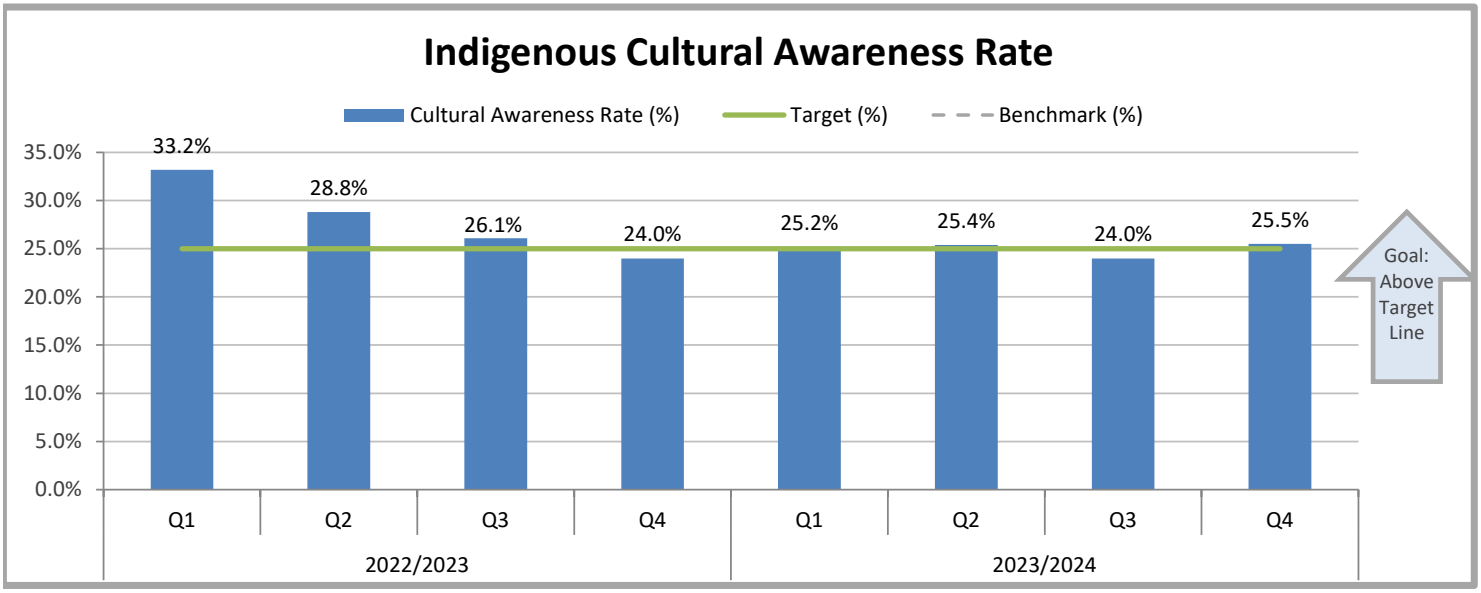
Significance: As part of our CCH Strategic Plan for 2016-2021, it identifies that CCH will partner with experts and our peers to foster a climate of culture competency. We will increase access to training with a focus on frontline staff, create a policy on smudging and plan to do at least one smudging ceremony, offer sessions that are more available to front line staff, and make reports available to managers and Chief of staff with number of participants. The Champlain Indigenous Health Circle Forum (Circle) works closely with the LHIN to improve health outcomes for Indigenous peoples across the region. The work of the Circle helps inform the LHIN on Indigenous health issues and needs and contributes to program planning and implementation. Circle activities include regular meetings focused on planning and engagement, and participation in
training and other events.

Data Source: Internal Tracking. Reported cumulatively year-to-date.

Target Information: Target is set at 25.0% in accordance to HSAA Obligation

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Cultural Awareness Rate (%)	33.2%	28.8%	26.1%	24.0%	25.2%	25.4%	24.0%	25.5%
Benchmark (%)								
Target (%)	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%



Performance Analysis:

Q1 Target met.
Q2 Target met.
Q3 Target not met. For Q3 there were only 53 staff who completed orientation compared to 64 from prior quarter.
Q4 Target met. Q4 had 75 staff who completed Indigenous training.

Plans for Improvement:

Q1 Continue with current strategy.
Q2 Continue with current strategy.
Q3 The current learning module is offered during new hire hospital orientation. Expand training to include current employees.
Q4 Continue with current strategy to expand training opportunities.

Accountable: Chief Human Resources Officer / Manager, Human Resources

Return to Dashboard

Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: PEOPLE

Definition: This is a mandatory QIP indicator. The number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period. Directive of Improvement is focused on building our reporting culture to increase the number of reported incidents.

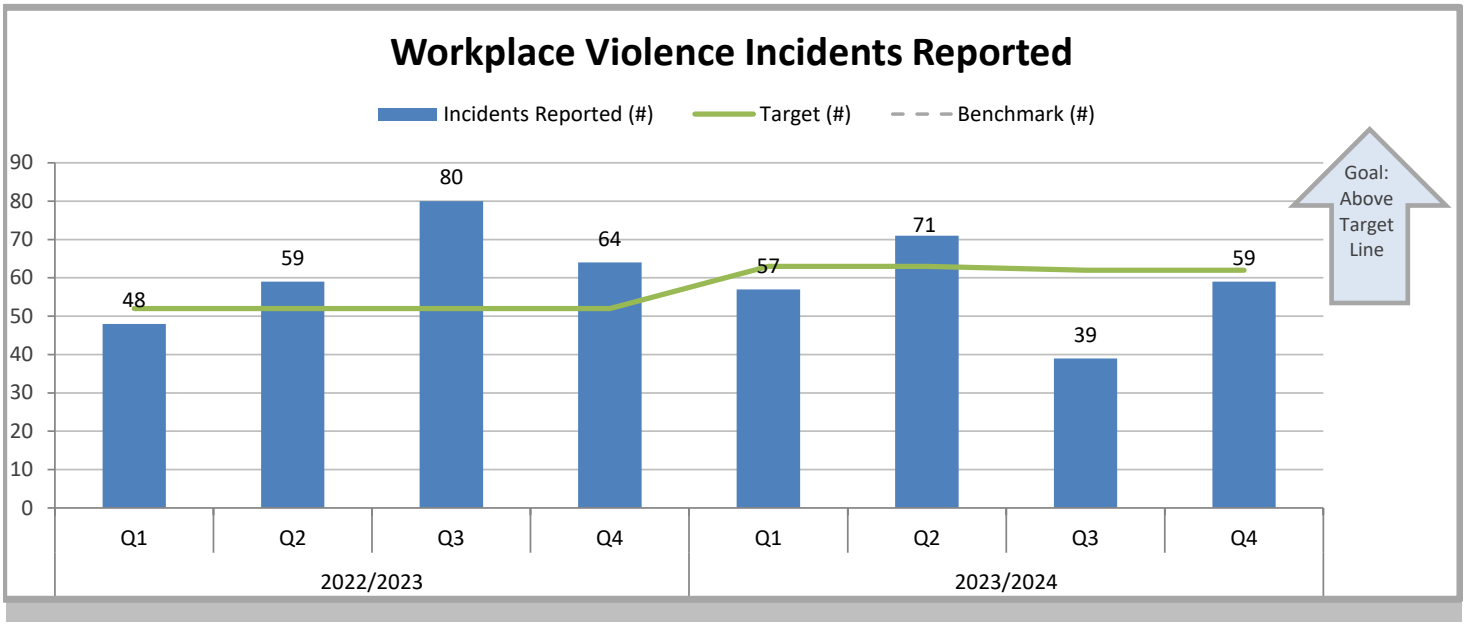
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like other injuries, injuries from violence are preventable. Reporting all incidents is done for the purpose of identifying priorities for intervention to reduce hazards.

Data Source: RL Solution -Incident Management System

Target Information: Target is set internally at 62.5 per quarter (total of 250 annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2022/2023				2023/2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	48	59	80	64	57	71	39	59
Benchmark (#)								
Target (#)	52	52	52	52	63	63	62	62



Performance Analysis:

Q1 Results slightly below target this quarter with 57 reported incidents due to Cyber Incident and lack of RL Solution

Q2 Target met.

Q3 Taget not met. October (7 incidents) and December (5 incidents) having lower reported incidents are contributing to target not being met for Q3.

Q4 Target not met. Of the 59 incidents reported in Q4, 6 incidents were reported late for Q3 and 53 were for Q4; 19 incidents occurred in Medicine, with an incidence rate of 35%.

Plans for Improvement:

Q1 Continue to work on recovery of RL Solution. Violence & Harassment subcommittee of the Joint Health & Safety Committee will be meeting in September to schedule Violence reporting awareness education at departmental team huddles. Currently reviewing the Code White process for opportunities for reporting improvements.

Q2 Continue with current strategy.

Q3 Reporting was below target mainly due to the requirement of manual reporting as the RL Solution system is being rebuilt.

Q4 Continue with current strategy as we rebuild the electronic reporting system.

Accountable: Chief Human Resources Officer / Manager, Human Resources

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