Cornwall Community Hospital
Hôpital communautaire de Cornwall

QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2021/2022

Vision: Exceptional Care. Always.

Mission: Our health care 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.

PATIENT INSPIRED CARE					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Patient Experience Survey: Information	QIP	R	Y	R	Y
Repeat Emergency Visits for Mental Health	QIP	G	G	G	G

PARTNERING FOR PATIENT SAFETY AND QUALITY OUTCOMES					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Discharge Summary Sent to Primary Care Within 48 Hours	QIP	Y	G	G	Y
Emergency Visits - Wait Time for Inpatient Bed (TIB)	QIP/OPT	G	R	R	R
Inpatients Receiving Care in Unconventional Spaces/Day	QIP	G	G	G	G
Medication Reconciliation on Discharge Rate (ROP)	QIP/Accreditation	Y	Y	G	Y

OPERATIONAL EXCELLENCE THROUGH INNOVATION					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**

OUR TEAM OUR STRENGTH					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Workplace Violence Prevention - Incidents	QIP	R	R	R	R

Results:

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

Reference Definitions:

Accreditation - Accreditation Canada

OPT - (Annual) Operating Plan Target

QIP - Quality Improvement Plan

Return to Dashboard

Indicator: Patient Experience Survey - Information Inpatient

Strategic Direction: Patient Inspired Care

Definition: Percentage of Inpatient respondents who responded positively (positive response include "completely" and "quite a bit") (Top2Box) to "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?" (Question #38).

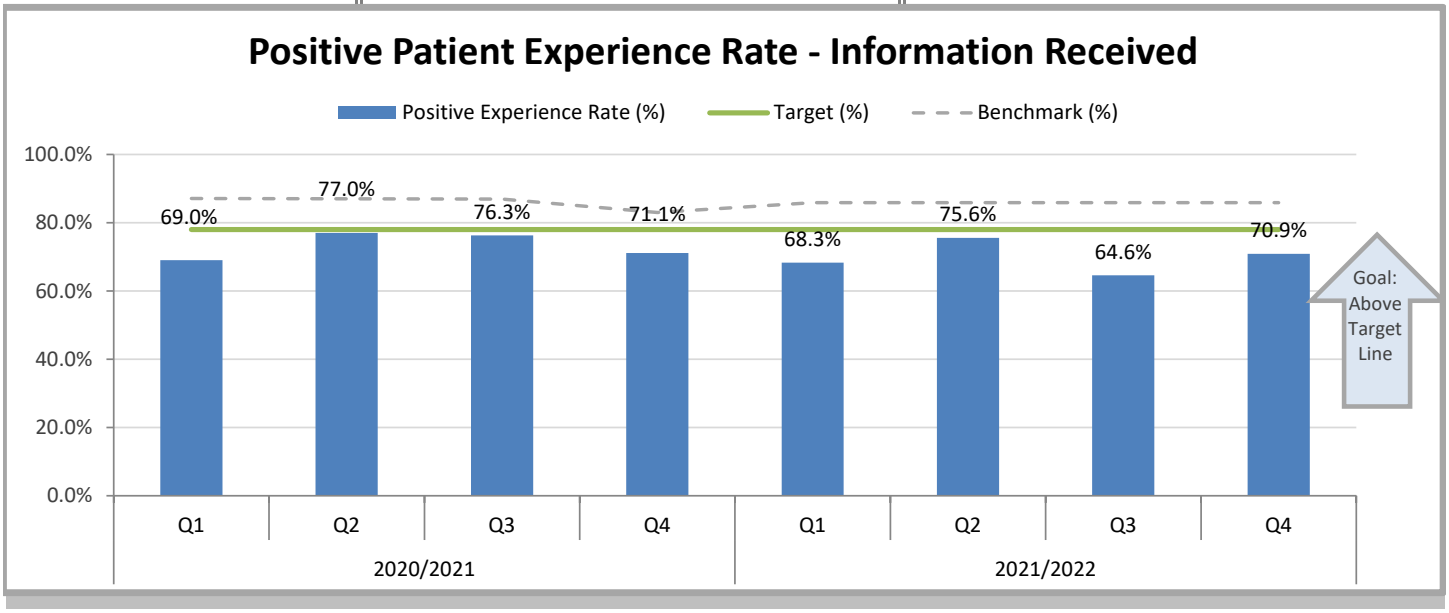
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that is sensitive to patients' concerns and comfort, and that actively involves patients and family members in shared decision-making about their care."

Data Source: NRC (National Research Corporation)

Target Information: New target set at 78%.

Benchmark Information: Benchmark performance is based on NRC - Champlain LHIN average quarterly performance

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	69.0%	77.0%	76.3%	71.1%	68.3%	75.6%	64.6%	70.9%
Benchmark (%)	87.1%	87.0%	86.9%	83.0%	85.9%	85.9%	85.9%	85.9%
Target (%)	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

Q1 Target not met. The biggest impact on Q1 were the low results for June at 60%; April results were 64.3% and May 73.3%.

Q2 Results slightly below target for this quarter. The results for Q2 include July at 72.4%, August at 73.1% and September at 77.7%.

Q3 Target not met. The results of Q3 include October at 76.1%, November at 60.5% and December at 61.1%. The gains made in Q2 have been lost and despite being in a pandemic our provincial peers were able to maintain their targets for Q3

Q4 Target not met. The results for Q4 include January at 70.8% and February at 70.9%. March data is not included in Q4 due to analysis calculated over an 11 month period.

Plans for Improvement:

Q1 Quality and Risk (Q&R) will review the results with Nursing Leadership and work on an action plan. The distribution of the discharge folder were meant to facilitate this indicator but other strategies may need to be considered.

Q2 While still below target there is improvement to trend line. Q&R will review opportunities identified through feedback, with inpatient managers, to establish an action plan.

Q3 Results will be shared with Nursing Leadership as well as trends in patient experience feedback (qualitative) and a plan developed during Q4 for implementation 2022-23.

Q4 Results will be reviewed with Nursing Leadership. While still below target there has been improvement compared to Q3.

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Quality and Risk

Quality Improvement Plan Scorecard FY 2021/2022

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Indicator: Repeat ED Mental Health Visits

Strategic Direction: Patient Inspired Care

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.

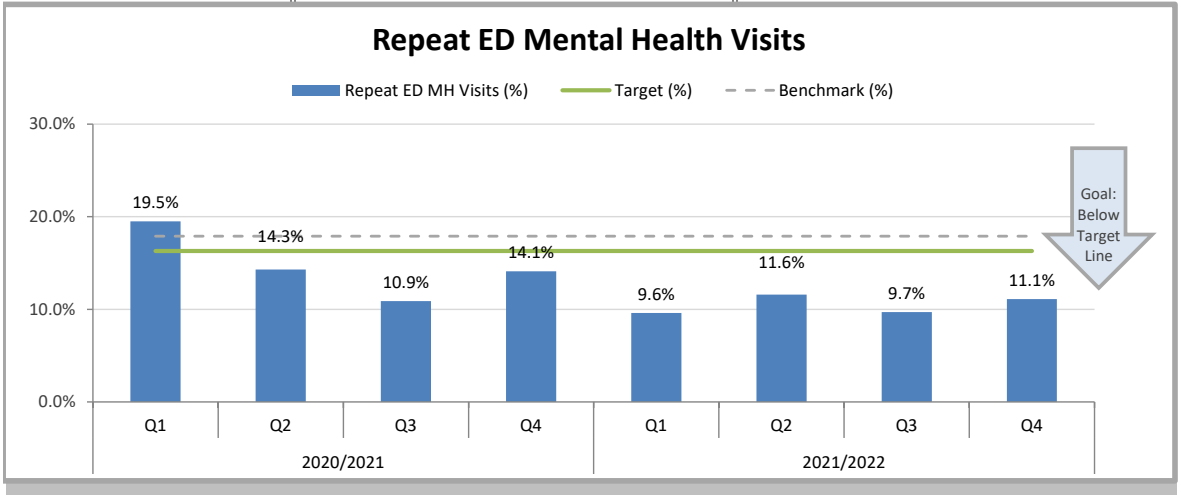
Significance: Repeat emergency visits among those with mental health conditions contribute to emergency visit volumes and wait times. Repeat emergency visits generally indicate premature discharge or a lack of coordination with post-discharge care. Given the chronic nature of the mental health conditions, 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

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Repeat ED MH Visits (%)	19.5%	14.3%	10.9%	14.1%	9.6%	11.6%	9.7%	11.1%
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 Data for Q1 is reported on and all coding has been completed. Total visits to the ED for mental health was 313. Of these, 30 were repeat visits representing 9.6% and well below our target of 16.3%. There was a reduction in clients with 3 or more repeat visits.

Q2 Data for Q2 is reported on and all coding has been completed. Total visits to the ED for mental health was 296. Of these, 34 were repeat visits representing 11.5% and below our target of 16.3%.

Q3 Data for Q3 is reported on and all coding has been completed. Total visits to the ED for mental health was 290. Of these, 28 were repeat visits representing 9.7% and well below our target of 16.3%.

Q4 Data for Q4 is reported on and all coding has been completed. Total visits to the ED for mental health was 298. Of these, 33 were repeat visits representing 11.1% and below our target of 16.3%.

Plans for Improvement:

Q1 Continue to monitor repeat visits in real time and follow-up where needed. Utilize power form in Cerner consistently and continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health.

Q2 Have been working collaboratively with both Cornwall Police Service and OPP to submit grant and funding proposals to sustain and enhance our co-response services. One key goal of co-response is ED diversion. Received funding to develop Safe Bed program which also has a key goal of ED/admission diversion. Continue to monitor repeat visits in real time and follow-up where needed. Utilize power form in Cerner consistently and continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health.

Q3 OPP grant submission was successful and will continue to work closely with the OPP to enhance our co-response services (unfortunately CPS grant submission was not successful and will continue our current co-response collaboration). One key goal of co-response is ED diversion. Safe Bed program development is firmly underway with estimated launch in April. Safe beds also has a key goal of ED/admission diversion. Continue to monitor repeat visits in real time and follow-up where needed. Utilize power form in Cerner consistently and continued focus on discharge planning and collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health.

Q4

Continue to work closely with police services in our co-response services. Safe Bed program has launched and has a key goal of ED/hospital admission diversion. Will continue to monitor repeat visits in real time and follow-up where needed and focus on discharge planning/collaboration between community programs and IMHU including collaborative case planning between ED, Community Programs and Inpatient Mental Health.

Accountable: VP, Community Programs / Director, Community Addiction and Mental Health Services

Return to Dashboard

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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.

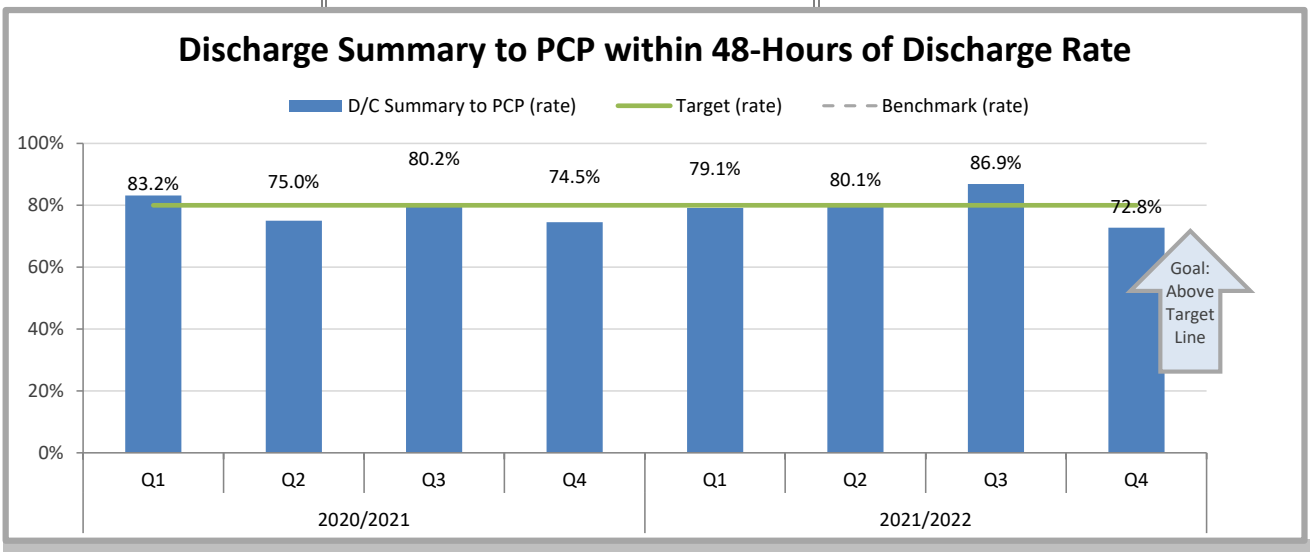
Significance: Health Quality Ontario (HQO) explains "Patients who have multiple conditions and complex needs may require care across different health care settings (e.g., hospitals, family physicians, etc.), which could potentially pose serious risks to their safety and quality of their care. Incomplete 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

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
D/C Summary to PCP (rate)	83.2%	75.0%	80.2%	74.5%	79.1%	80.1%	86.9%	72.8%
Benchmark (rate)								
Target (rate)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Despite a 6% increase in improvement over last quarter Q1 results remain slightly below target. There was a total of 1284 applicable discharges with 1016 discharge summaries sent to the primary care provider within 48 hours.

Q2 Target met. There was a total of 1391 applicable discharges with 1114 discharge summaries sent to the primary care provider within 48 hours.

Q3 Target met. There was a total of 1224 applicable discharges with 1064 discharge summaries sent to the primary care provider within 48 hours.

Q4 Target not met. There was a total of 1203 applicable discharges with 876 discharge summaries sent to the primary care provider within 48 hours.

Plans for Improvement:

Q1 We have implemented processes to work with the physician and midwifery groups in order to ensure compliance with this indicator. Chief of Staff was engaged to assist with communication. Optimization of documentation practices continues in order to ensure efficiency for providers.

Q2 Q1 efforts resulted in a slight improvement for Q2. Currently meeting target. We continue to communicate the importance of ensuring documentation is complete within a timely manner in order to allow for proper follow-up. Strategies implemented at Q1 will continue to be monitored and reinforced.

Q3 Exceeding target at Q3. Processes in place are working. The teams continue to work together to support physicians in ensuring timely completion of documentation. Also focusing on ensuring data quality in the 'Primary Care Provider' field of the electronic health record so that we can be confident that our information is being distributed to the community partners who need it. Will continue to monitor.

Q4 Target not met. There was a significant decrease from Q3 performance. It is anticipated that the project work being done with the Hospitalist program and Master's students will have a positive impact on patient flow within the organization. One of the expected results is an improved workflow for our Hospitalists. This initiative coupled with ongoing support and data quality review will result in recovery for Q1 of fiscal year 2022/23.

Accountable: Chief Information and Operations Officer / Manager, Patient Flow

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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.

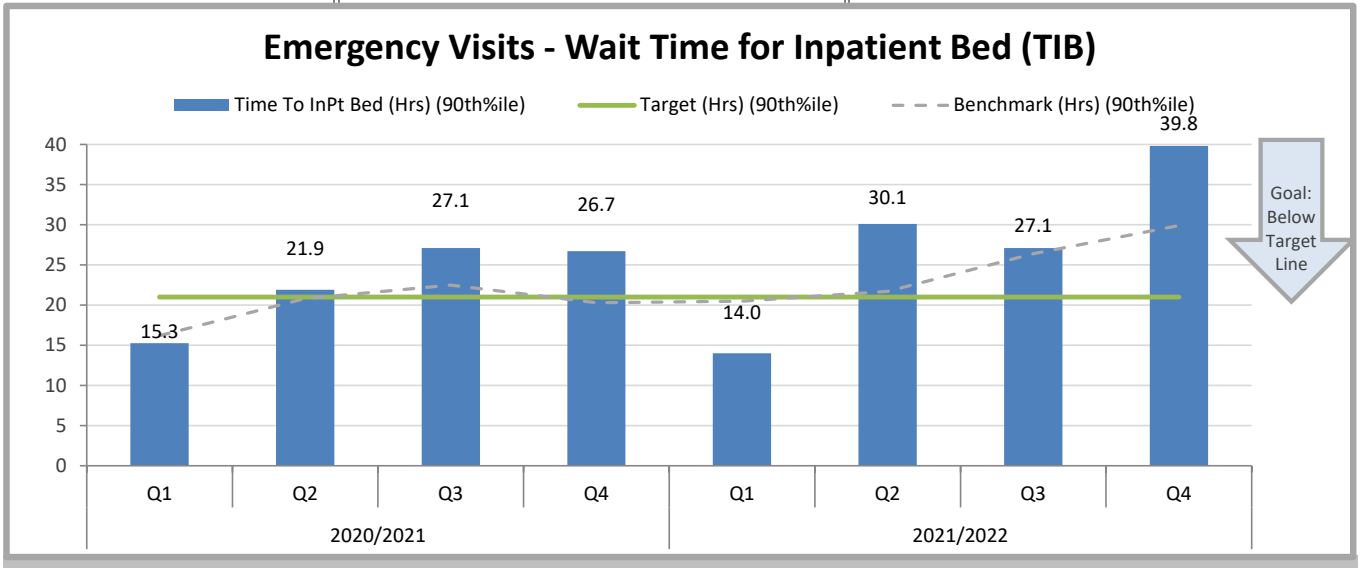
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the 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. Established at 5% reduction of prior FY1920 (Q1-Q4) performance of 22.2.
*Formula is 22.2 * (1 - 5%) =21.0

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'High-Volume Community Hospital Group' results in Q1; effective FY2021-Q2, benchmark performance is based on ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results due to our emergency visits dropping to just under 50,000 visits in FY1920.

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	15.3	21.9	27.1	26.7	14.0	30.1	27.1	39.8
Benchmark (Hrs) (90th%ile)	16.2	20.8	22.5	20.3	20.5	21.7	26.4	29.9
Target (Hrs) (90th%ile)	21.0	21.0	21.0	21.0	21.0	21.0	21.0	21.0



Performance Analysis:

Q1 Target met.
Q2 Target not met.
Q3 Target not met.
Q4 Target not met.

Plans for Improvement:

Q1 During Q1, CCH maintained additional surge capacity which accommodated the increased inpatient volumes and allowed for shorter wait times to inpatient beds. CCH continues to maintain expanded inpatient capacity through the use of hall way beds and additional surge areas.

Q2 In Q2, CCH made changes to our surge capacity due to low nursing staffing (consolidated multiple surge areas to Day Surgery). We were unable to occupy hallway beds on the inpatient units due to Universal Isolation Precautions which led to having fewer medical beds available for admitted patients and therefore holding more medical admits in the Emergency, for a longer period of time. The EDs in the region saw similar trends.

Q3 In Q3 CCH continued to staff and expand our surge capacity areas. We were unable to occupy hallway beds on the inpatient units due to Universal Precautions. The EDs in the region saw similar trends. CCH has MBA students who are currently assessing the inpatient flow.

Q4 In Q4 CCH continued to maintain surge capacity beds to maintain additional inpatient beds. We were unable to occupy inpatient hall way beds on the inpatient units related to Infection Control restrictions. There were multiple outbreaks (MRSA, COVID-19, etc.) that impacted the Inpatient flow out of the Emergency Department.

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

Return to Dashboard

Indicator: Inpatients Receiving Care in Unconventional Spaces per Day

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: This indicator measures the average number of inpatients admitted to bed/stretcher, etc. that is placed in an unconventional space to receive care at 12am. (Excludes patients admitted and discharged within same day). An unconventional space is an area in a hospital, which has been enabled to place beds to provide care to inpatients. Unconventional spaces refer specifically to the placement of a bed in any place spacious enough, i.e. an office, hallways, including hallways in the emergency department or inpatient unit, or auditorium that does not meet the required fire and safety standards. Patients placed in beds in unconventional spaces do not have access to nurse call-bell, washrooms, suction, oxygen, etc.

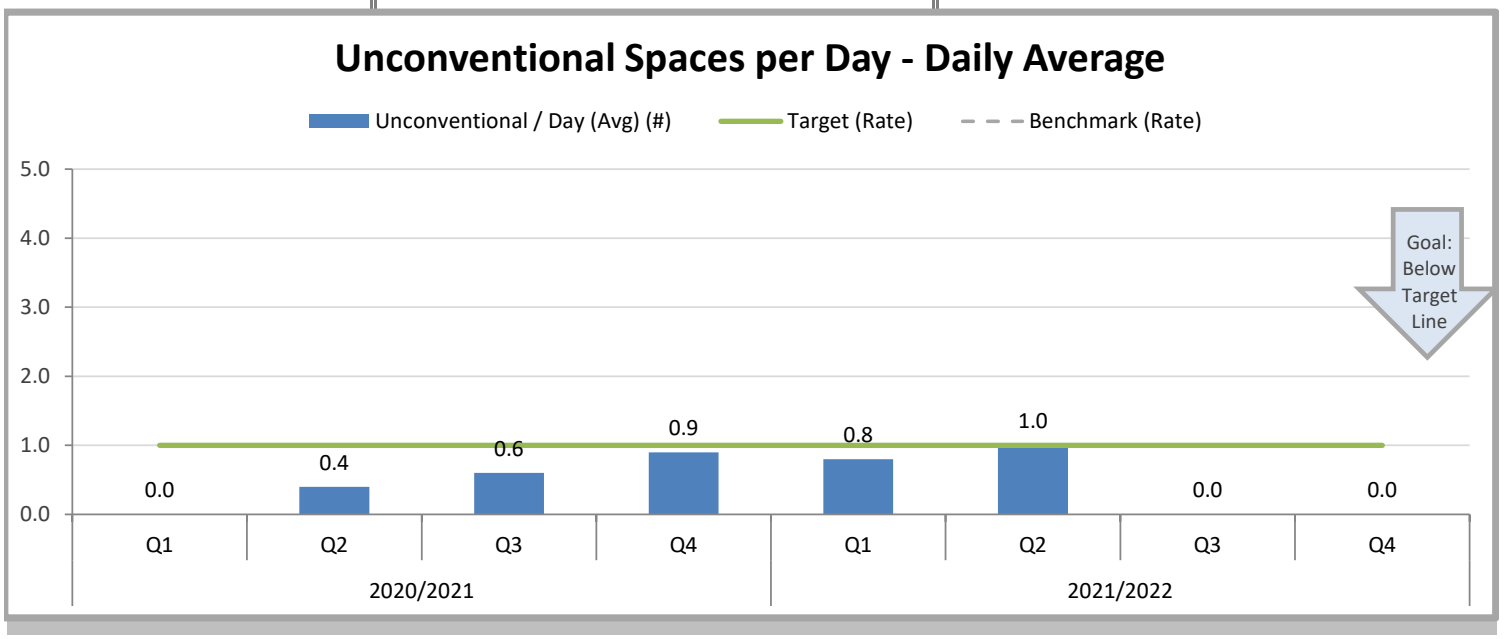
Significance: This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces during the third quarter, 2018/19. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity in Ontario hospitals during this time. In conjunction with other indicators such as time to inpatient bed and the ALC rate, this indicator can be used to monitor a hospital's space capacity and contribute to a better understanding of the issue.

Data Source: Cerner - Discern Analytics (Daily Census Report)

Target Information: Target set internally; in accordance to QIP indicator

Benchmark Information: N/A

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Unconventional / Day (Avg) (#)	0.0	0.4	0.6	0.9	0.8	1.0	0.0	0.0
Benchmark (Rate)								
Target (Rate)	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0



Performance Analysis:

Q1 Target met.
Q2 Target met.
Q3 Target met.
Q4 Target met.

Plans for Improvement:

Q1 Continue with current process.
Q2 Continue with current process.
Q3 Continue with current process.
Q4 Continue with current process.

Accountable: Chief Information and Operating Officer / Manager, Patient Flow and Bed Management

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

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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 - Obstetrical and Newborn patients).

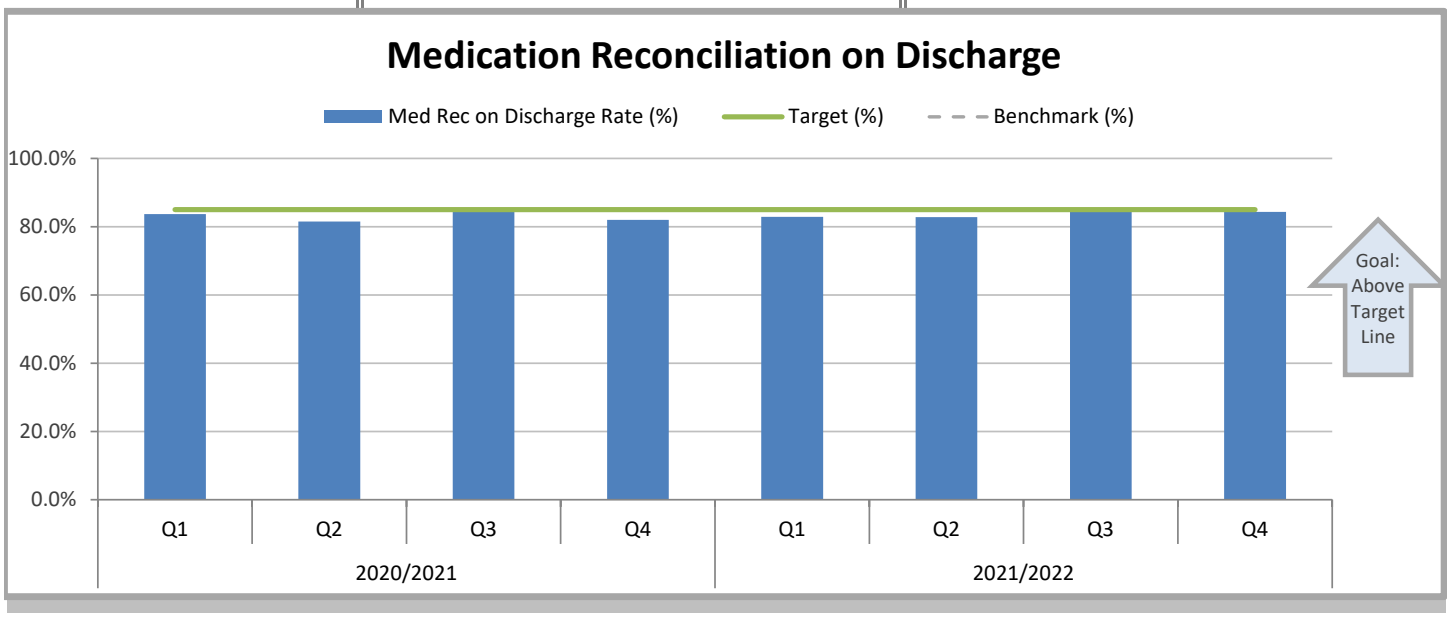
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a 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

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	83.7%	81.5%	84.7%	82.0%	82.9%	82.8%	85.0%	84.3%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target not met. Below target are CCU at 39% and Level 4 MH at 74% for this quarter.

Q2 Target not met. Below target are CCU at 43.8% and Level 2 Surg at 75% for this quarter.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 Investigating further into CCU results. This will also be brought to the departmental meetings to discuss a plan for improvement with physicians.

Q2 CCU Manager reminding physicians to complete Medication Reconciliation at discharge, and for nurses to remind physicians of such when a patient is being discharged. Challenges are that patients often get transferred via Ornge where the medication reconciliation on discharge does not get done, or patients are transferred out of CCU overnight and the MRP is not on site.

Q3 CCU Manager worked with Clinical Informatics to no longer include patients being transferred to Inpatient Mental Health and/or Rehab (which is considered a discharge in Cerner). Also, inpatient deaths are no longer included in the data. This allows the data to be more accurate.

Q4 Target met. Evaluation of data has allowed for accurate results moving forward.

Accountable: Chief Information and Operating Officer / Chief of Staff

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Indicator: Workplace Violence Prevention - Incidents Reported

Strategic Direction: Our Team Our Strength

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.

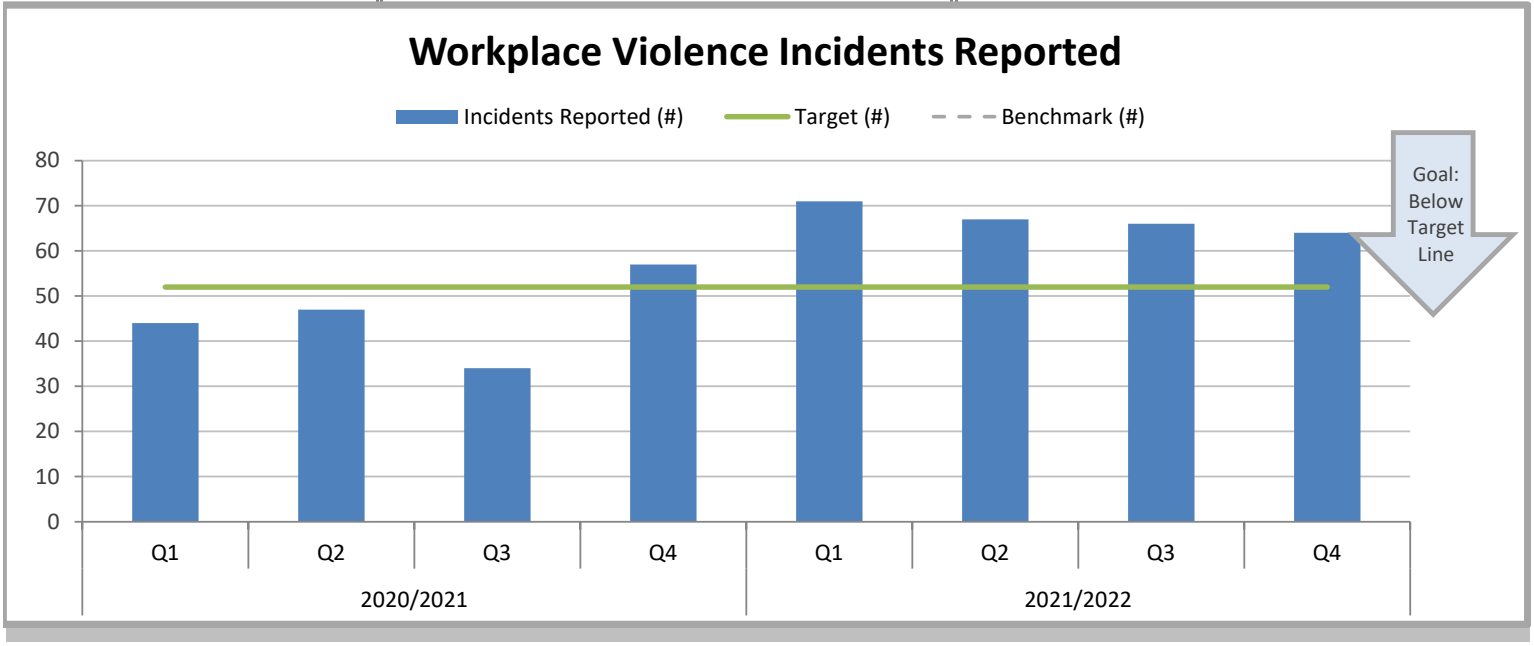
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like 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 52 per quarter (total of 210 annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2020/2021				2021/2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	44	47	34	57	71	67	66	64
Benchmark (#)								
Target (#)	52	52	52	52	52	52	52	52



Performance Analysis:

Q1 Target not met.
Q2 Target not met.
Q3 Target not met.
Q4 Target not met.

Plans for Improvement:

Q1 Continue with current strategies. Implement solution for root cause of reported incidences.
Q2 Reviewing trends with Joint Health and Safety Committee (JHSC) to look at strategies.
Q3 Conduct a threat assessment in key identified areas and continue to promote staff training (i.e. NVCI).
Q4 JHSC taking this as a goal for the committee this new fiscal year.

Accountable: Chief Privacy and Human Resources Officer / Manager Human Resources

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