Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

2023-2024

Cornwall Community Hospital
Hôpital communautaire de Cornwall

Ontario Health

## OVERVIEW

Cornwall Community Hospital (CCH) is dedicated to the delivery of exceptional care and to continually enhancing the quality and safety of care in an environment that reduces risk for patients and staff. CCH prides itself on caring for the community, in the community. Our partnerships with each hospital within the eastern district are strong and we are thankful for these collaborative relationships. We are immensely proud of our people for their strong presence; their commitment to teamwork ensuring our patients continue to receive Exceptional Care. Always.

This year, CCH underwent an exercise of engagement internal to the organization, with our partners in care, academic affiliations, and with our community stakeholders to update our Strategic Directions. After extensive engagement, Leading Innovative Transformation was designed creating directions for 2022 to 2027. The 3 directions include Recovery – enhancing access to care, committing to operational excellence, advancing innovation, maintaining a culture of quality and safety, and establishing physical capacity. People – Inspired by patients and care partners, supporting the wellbeing of our people, engaging, and cultivating a high performing team, building a culture of equity, diversity, and inclusion, and embracing reconciliation and stewarding our environmental and social responsibilities. Integration – Creating sustainable models of care, supporting transitions in care, advancing collaborative partnerships, and promoting health system integration.

The 2023/24 Quality Improvement Plan will build on initiatives from the previous year's plan to further enhance the quality and safety of care delivered: focusing on transitions of care by ensuring timely,

meaningful discharge information, and reducing likelihood of hallway medicine by improving access to inpatient beds. Our focus was and continues to be to improve wait times in the Emergency Department. Indirectly, the improvements chosen are intended to improve the patient, family, and caregivers' experience along their continuum of care. Furthermore, the plan has focus on enhancing patient safety through improvements to our medication administration processes through the addition of a custom indicator. These initiatives will work together in keeping our patients and staff safe while promoting quality of care.

## PATIENT/CLIENT/RESIDENT ENGAGEMENT AND PARTNERING

At CCH, engaging and partnering with patients and their families is integral to our quality improvement work. We are committed to providing high-quality, safe, and excellent patient experience by ensuring the voice and perspectives of patients and families are considered across the continuum of care and services. Through collaboration with the Patient and Family Advisory Committee (PFAC), patients and caregivers contribute to quality improvement initiatives by sharing their experiences and making recommendations in how we plan and deliver quality, safe, and excellent healthcare services.

The Essential Care Partner (ECP) Program project included members of PFAC as well as caregivers that had recent experiences at CCH. Through meetings and focus group sessions, their unique perspectives and voices were well considered and guided our work. The objective of the ECP Program project is to foster a culture that supports patient and family partnerships in care, acknowledging the vital role those relationships have in contributing to positive health outcomes.

These collaborations and partnerships strengthen relationships and enhance the patient, family, and provider experience.

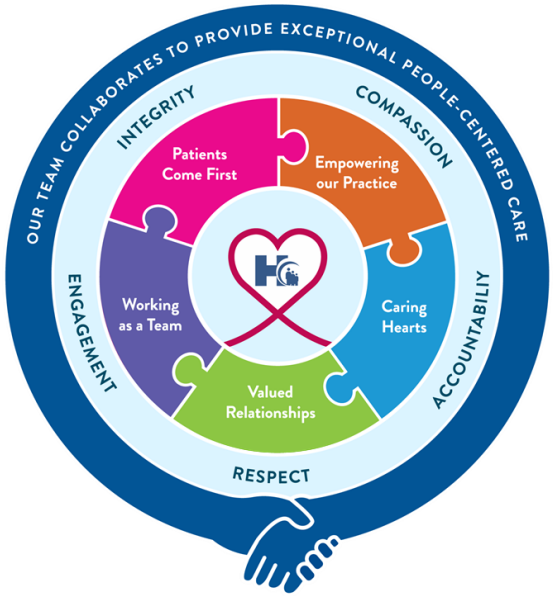
## PROVIDER EXPERIENCE

The Heart of Exceptional Care

2022 has seen the launch of CCH's Professional Practice Model, The heart of exceptional care. The model was developed following several months of engagement with our patient-facing staff and physicians as well as patient and family advisors. The final model represents our collective voices and priorities as collaborative care

team, aligning directly with CCH's Mission and ICARE values, and will lead the way for continuous quality improvement driven by frontline initiatives. It is the driving force of clinical care and shows how regulated professionals & partners practice, collaborate, communicate and develop professionally to provide the highest quality care possible.

Figure 1:




Working as a Team: We use collaborative design and care approaches to deliver exceptional care to every patient, every time.
Patients Come First: We focus on patient safety and excellent patient outcomes as the foundation of all we do. Valuing the patient experience and creating effective processes to measure, evaluate and continuously improve.
Empowering our Practice: We share our knowledge to develop professionally. We care for patients the way we expect to be cared for.
Caring Hearts: We care for patients with maturing models of care delivery that includes the holistic patient.
Valued Relationships: We always celebrate each other and build relationships making strong ties with a collaborative approach.

This model becomes everything that we do to improve care outcomes and guide our principles for professional practice, care delivery and education.

## WORKPLACE VIOLENCE PREVENTION

Workplace violence is a growing concern across healthcare sectors. At CCH we know that violence against our workforce affects us all. It has a great impact on our employees, their families, and our community. Once again, we have included workplace violence incidents as a focus on our QIP. As evidenced in our strategic plan, Recovery: maintaining a culture of quality and People: safety and supporting the well-being of our people are priorities for us. A robust action plan to target workplace violence was developed and outlines specific objectives and actionable items with a goal of identifying root causes and gaps through analysis, communication, and collaborative efforts to work towards a safe and sustainable work environment. We recognize that workplace violence is a complex issue that necessitates a commitment to the creation of a working environment that is safe for both workers, and patients.

## PATIENT SAFETY

Guided by our Integrated Patient Safety and Quality Plan, CCH seeks to achieve our strategic directions by maintaining a culture of quality and safety that is inspired by patients and families. We have adopted the Canadian Quality and Patient Safety Framework to steer our efforts in delivering Exceptional Care. Always. To support quality improvement and enhance a safe and just culture, patient safety incidents are reviewed and analyzed through a structured framework. Our process includes fostering a safe and just culture for all, maintaining an incident reporting platform and providing training to all employees, analyzing all patient safety incidents, identifying gaps and opportunities for learning and improvements, and sharing these findings across the multi-disciplinary teams.

The Interprofessional Quality and Practice Committee, Safe Medication Working Group, and Nursing Leadership, all multi-disciplinary teams, review patient safety incidents at regular intervals and advise, communicate, and guide professional practice quality improvement projects. The objective is to support an organizational culture of professionalism, uphold practice standards and promote excellence through interprofessional collaboration while ensuring quality patient care with a focus on safety.

## HEALTH EQUITY

At CCH, we recognize how vital it is to foster and support equity, diversity, and inclusion (EDI). We understand that inequities exist in the Canadian healthcare system and that those can negatively impact our patients, families, and providers. Our commitment to delivering collaborative and compassionate care that recognizes the need to promote health equity is outlined in our strategic plan, People: building a culture of equity, diversity, and inclusion, and embracing reconciliation.

In early 2023, CCH partnered with Cornwall Police Services to take measurable positive action in promoting equity, diversity, and inclusivity through the recruitment of an EDI Coordinator. The shared resource between CCH and CPS will provide strategic guidance on EDI and help implement initiatives within the organizations.

Additionally, we aim to close the gaps of health inequities with targeted efforts to best support the Akwesasne First Nations Community that we serve. We are adding an Indigenous Patient Navigator to our team that will provide support and comfort while mitigating barriers through a patient-centered approach. Our goal is to improve access and ensure the Indigenous patients' experience is culturally safe and inclusive.

We acknowledge that health equity is achieved when all persons can attain their full potential for health and well-being through fair opportunities and that this work will be long-term and continuous. We look forward to our work in continuing to support our team and patients in making EDI a priority.

## EXECUTIVE COMPENSATION

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

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

- President and Chief Executive Officer
- Vice-President, Patient Services and Chief Nursing Officer
- Vice-President, Community Programs
- Chief Financial Officer
- Chief Information and Operating Officer
- Chief of Staff

## CONTACT INFORMATION

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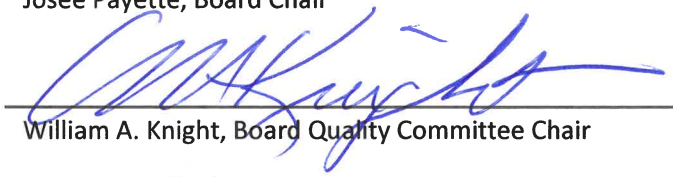
## SIGN-OFF

I have reviewed and approved our organization's Quality Improvement Plan on March 9, 2023.

Josée Payette, Board Chair



William A. Knight, Board Quality Committee Chair

Jeanette Despatie, Chief Executive Officer

Linda Gravel, Vice-President, Patient Services, and Chief Nursing Officer

# 2023/24 Quality Improvement Plan
# "Improvement Targets and Initiatives"

Cornwall Community Hospital 840 McConnell Avenue, Cornwall , ON, K6H5S5

| AIM | | Measure | | | | | | | | | Change | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Issue | Quality dimension | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification | External Collaborators | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments |
| M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on) | | | | | | | | | | | | | | | |
| **Theme I: Timely and Efficient Transitions** | **Efficient** | Emergency Visits - Wait Time for Inpatient Bed (TIB) (Hours) (90th Percentile). The indicator is measured in hours using the 90th percentile, which represents the time interval between the Disposition Date/Time Patient Left ED for admission to an Inpatient bed or Operating Room. | C | 90th percentile / All patients | CIHI NACRS / Oct - Dec 2022 | 967* | 30.1 | 28.30 | Target established based on ATC-Ranking Peer Hospital results for Medium Hospitals using prior year (Dec-Nov) median 90th percentile results. | | 1)Continue corporate monitoring of TIB with goal of meeting or exceeding target. | Track (TIB) through Daily Access Reporting Tool (DART) + Pay-for-Results (P4R). | Collaborating with Patient flow to maintain surge beds, optimize hallway beds and maximize inpatient capacity to reduce TIB. | That by Q4, TIB will be less than or equal to peer results. | Surge beds and hallways beds are maintained to meet TIB target. |
| | | | | | | | | | | | 2)Review current state of TIB per department and look for improvement strategies. | Collaborate with decision support to retrieve real-time internal data that is actionable in terms of TIB to each individual inpatient unit. | Review the data provided by decision support. | That by Q4, TIB will be less than or equal to peer result. | Collaborate with inpatient units. |
| | | | | | | | | | | | 3)Communication and collaboration between ED, Patient Flow and Inpatient Departments. | Explore the current Hospitalist Teams Model and collaborative approach with the care team to facilitate early discharge planning as part of organizational culture and philosophy of care. | Initiate process within the current Hospitalist Teams Model to better support the ED. | Implement 50% of process improvements as identified by Q4. | Re: EMS support, support in the ED, increase throughout. |
| | **Timely** | Repeat ED Mental Health Visits | C | % / ED patients | CIHI NACRS / Apr - June 2022 | 967* | 12.9 | 16.30 | Target established through HSAA agreement. Current performance of 12.9% for Apr-June.2022. | | 1)Review current state of repeat mental health visits to the Emergency Department and develop improvement strategies to reduce revisits. | Collaborate with decision support to retrieve real-time internal data that is actionable. | Internal revisit reports generated on a monthly basis. | Actionable report generated every month by Q1. | |
| | | | | | | | | | | | 2)Establish ED Working group to review and audit repeat ED MH charts to look for improvement opportunities | Utilize existing ED working group | Confirm members and purpose of audit review | That by end of each quarter, 100% of audits from previous quarter will be completed. | |
| | | | | | | | | | | | 3)Promote awareness and optimize information shared with ED regarding available MH services. | Awareness sessions on Outpatient Mental Health Services for working group members. | 3 sessions on Outpatient Mental Health Services (MHCT, WDMS, Child and Youth MH Services). | That by Q4, 100% of three sessions will be complete. | |
| | | | | | | | | | | | 4)Explore available resources to better support the ED with MH patient population. | Collaborate with decision support to retrieve real-time internal data that is actionable in terms of consult to these services. | Reports of internal and outpatient referrals to mental health services generated on a monthly basis. | Review monthly reports 100% of the time. | |
| **Theme III: Safe and Effective Care** | **Effective** | Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. | P | Rate per total number of discharged patients / Discharged patients | Hospital collected data / Oct–Dec 2022 (Q3 2022/23) | 967* | 89 | 85.00 | Continue to maintain or exceed prior Fiscal Year 2022-2023 performance.(Indicator excludes death, inter-facility transfers, ED holds, Obstetrics & Pediatrics) | | 1)Enhance information shared from hospital to community partners obtained via medication reconciliation at discharge to promote patient safety. | Audits through the electronic health record. | Number of patients with medication reconciliation completed at discharge/number of discharges. | 85% of patients will have medication reconciliation completed on discharge by July 2023. | |
| | | | | | | | | | | | 2)Promote awareness of polypharmacy at the Senior Friendly Committee (Senior Friendly initiative). | Track the number of patients discharged that are greater than or equal to 65 years of age that have medication reconciliation, to highlight and explore opportunities for education at the Senior Friendly Committee. | Ongoing agenda item on Senior Friendly Committee. Number of patients that are greater than or equal to 65 year of age that have medication reconciliation completed at discharge/total number of patients discharged that are greater than or equal to 65 year of age. | 85% of patients will have medication reconciliation completed at discharge. 90% of CCU patients discharged home from the unit will have med reconciliation completed at discharge. | |

| AIM | | Measure | | | | | | | | | Change | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Issue | Quality dimension | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification | External Collaborators | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments |
| | | Discharge Summary Sent to Primary Care within 48 Hours. 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. | C | Count / Discharged patients | In house data collection / Oct - Dec 2022 | 967* | 82.4 | 80.00 | Baseline established | | 1)Continue to optimize structured documentation discharge templates to ensure timely exchange of information to primary care at discharge. | Provide training to physicians during onboarding to set up personal requests in templates and ensure strong understanding of technology/processes. | Number of new providers receiving training/ total number of new providers onboarded. | 80% by end of Q3 | |
| | | | | | | | | | | | 2)Explore system wide approaches to improving this process; minimize the number of incidents > 48 hrs | Track the turn-around time from discharge to distribution of the discharge summary to measure the percent received in 48 hrs; track and evaluate the turn-around time for completion of discharge notes at the physician-specific level | Number of discharge summaries "distributed" in 48 hrs/ total number of discharge summaries | 80% by the end of Q3 | |
| | **Safe** | Medication Scanning Compliance | C | Count / All inpatients and ED patients | Local data collection / Hospital collected data / Oct - Dec 2022 | 967* | 79.2 | 85.70 | Target justification baseline established through data from FY2022/23.Target set at 10% improvement of prior year performance (77.9 x *10% = 85.7). | | 1)Leverage Technology | Ensure scanners present at points of medication administration locations; Audit of WOWs recalibration stickers; Education/awareness of importance calibration, 5 day sequence of education through various methods; Ensuring accountability of calibration at a unit level. | Evaluate current state of operational equipment and resolving gaps; Complete audit; Complete 5 day events; Audit checklist. | By Q4: Reach 100% of plans in place to resolve any outstanding issues; Reach 100% audits and stickers in place; Reach 100% completion of 5 day event; 90% target reached of completed audits. | |
| | | | | | | | | | | | 2)Increase education to clinical staff on the use of Med Request M page (Mpage) medication scan issues reporting. | Evaluate current state of usage Mpage through development of report of medication barcode issue submissions. | Review report and develop processes to increase adherence to the use of the Mpage. | Development of report by Q3 and completion of education by Q4. | |
| | | | | | | | | | | | 3)Evaluation of medication scanning override options in the electronic health record (EHR). | Audit report on medication scanning override option usage. | Evaluation based on best practice electronic medication processes. | Succinct list as defined by best practice complete by Q3. | |
| | | Number of workplace violence incidents reported by hospital workers (as by defined by OHSA) within a 12 month period. Change in focus to build on reporting culture to increase number of reported incidents. | C | # incidents/department / Worker | Local data collection / Jan 2022 - Dec 2022 | 967* | 251 | 250.00 | New target established at 10% increase of prior year target (223), due to staffing increase. Focus this fiscal year is to increase the number of reporting of incidents to achieve baseline. | | 1)Increase awareness and understanding of workplace violence for all CCH staff, physicians and volunteers who interact with patients and the public. | Training and communication methods include - orientation (hospital and departmental); huddles and departmental meetings - both formal and informal; staff safety week initiatives; discussions with staff by members of JHSC during workplace inspections; initiatives with the communications coordinator | # huddles and training opportunities completed / quarter. | Conduct 60 huddles per quarter. | Reviewed at Workplace Violence and Harassment Sub-Committee to support action plan, as well as Joint Health and Safety Committee. |
| | | | | | | | | | | | 2)Create a culture of staff engagement to increase reporting of workplace violence incidents. | Explore ease of reporting through the incident reporting system, as well as measures to support providing feedback to the employees completing the reports. | # incidents reported per department compared to previous reporting. | 10% increase in reporting. | |
| | | | | | | | | | | | 3)Review and evaluate available training programs to increase access and compliance with mandatory training. | Review current state including, compliance rates with Non-Violent Crisis Intervention (NVCI), Gentle Persuasive Approach (GPA) and Workplace, Dignity & Respect (WDR) training, availability of instructors, number of courses offered annually, as well as opportunities to increase access for staff. Establishing a process to prioritize who accesses the training opportunities will support transparency and equity across departments. | % employees certified in advanced NVCI and abridged (overall rates and departmental rates). | 25% improvement in compliance rates for advanced NVCI and NVCI abridge by Q4. | |

| AIM | | Measure | | | | | | | | | Change | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Issue | Quality dimension | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification | External Collaborators | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments |
| | | | | | | | | | | | 4)Trending of incidents to set priorities and mitigation strategies and action plans for Violence and Harassment Subcommittee and Joint Health and Safety Committee (includes patient safety plans, staff safety plans, alerts, etc). | Identify common themes as evidenced through the incidents and discussions with staff, including multiple incidents with the same patient, triggers for certain patients, trends by departments, challenges resolving incidents. | # incidents / department as well as # of patients or visitors with 2 or more incidents. | 50% incidents involving 1 patient with multiple incidents will be jointly reviewed by OHS and manager quarterly. | |