Cornwall Community Hospital
Hôpital communautaire de Cornwall

QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2019/2020

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**
Complaints Acknowledged	QIP	G	G	G	G
Patient Experience Survey: Information	QIP	G	Y	G	G

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

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	G	G	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

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Indicator: Complaints Acknowledged Within Five (5) Business Days

Strategic Direction: Patient Inspired Care

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.

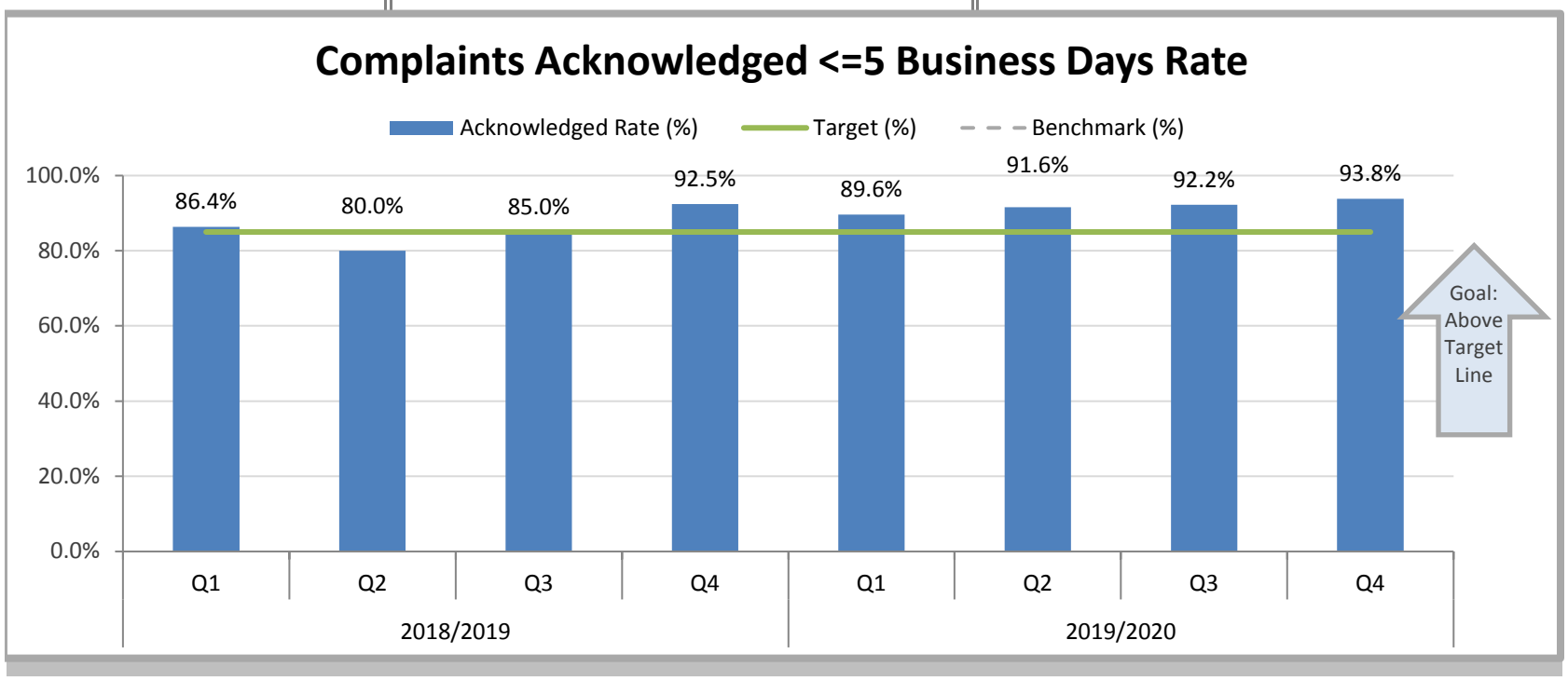
Significance: This indicator measures the percentage of complaints received by hospitals that were acknowledged to the individual who made a complaint. This indicator is calculated on the number of complaints received in the reporting period. By regulation, hospitals must acknowledge complaints within 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 85.0% in accordance to QIP indicator

Benchmark Information: N/A

	2018/2019				2019/2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Acknowledged Rate (%)	86.4%	80.0%	85.0%	92.5%	89.6%	91.6%	92.2%	93.8%
Benchmark (%)								
Target (%)	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%



Performance Analysis:

Q1 Target met. There were 43 complaints acknowledged out of the 48 total complaints for this reporting period.

Q2 Target met. There is a process to monitor compliance on an ongoing basis.

Q3 Target met. Acknowledged rate continues to surpass target.

Q4 Target met. Acknowledged rate continues to surpass target.

Plans for Improvement:

Q1 Continued focus on maintaining performance to acknowledge complaints in a timely manner.

Q2 Continue as above.

Q3 Continue as above.

Q4 Continue as above.

Accountable: VP, Patient Services and Chief Nursing Officer

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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).

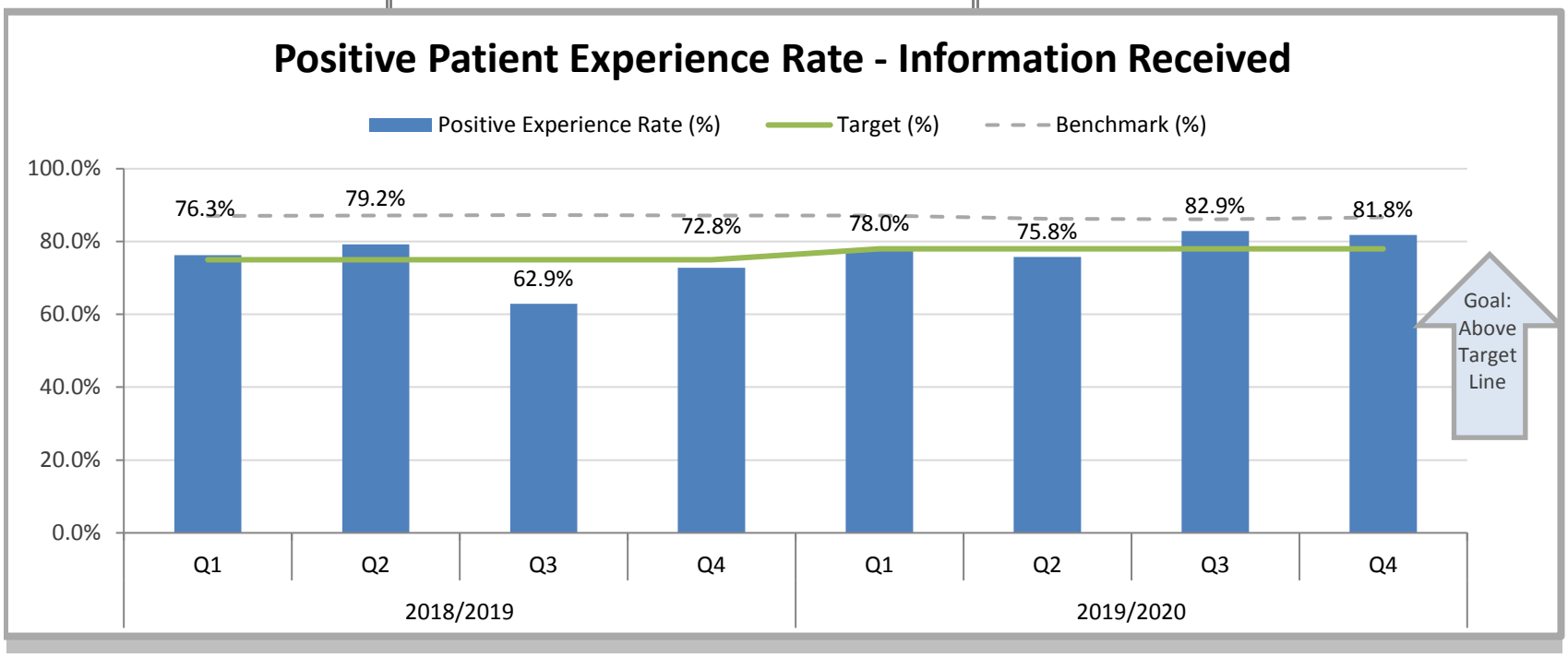
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that 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% in accordance to QIP indicator; a 5% increase to last prior year target of 75%.

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

	2018/2019				2019/2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	76.3%	79.2%	62.9%	72.8%	78.0%	75.8%	82.9%	81.8%
Benchmark (%)	87.0%	87.1%	87.3%	87.2%	87.1%	86.3%	86.1%	86.6%
Target (%)	75.0%	75.0%	75.0%	75.0%	78.0%	78.0%	78.0%	78.0%



Performance Analysis:

Q1 Target of 78% met. Results are trending upward.

Q2 Q2 results of 75.8% just shy of meeting suggested target of 78%. Response rate for Q2 is a bit low at 29.7% due to September being incomplete with closure date being mid December, and only showing a return response rate of 21.4%.

Q3 Target met.

Q4 Target met.

Plans for Improvement:

Q1 Continue to educate staff about the importance of PODS (patient oriented discharge summaries) usage and perform regular audits.

Q2 Continue as above. Initiation of weekly uploads to NRC starting November which should increase response rates as patients will receive surveys in a more timely manner. Email address collection initiated in Electronic Health Record by mid October and uploaded to NRC for distribution which should increase Q3 responses as well.

Q3 Continue as above. Initiation of weekly uploads to NRC starting November which should increase response rates as patients will receive surveys in a more timely manner. February 4th we started to distribute a Patient Information Folder, including a letter from J. Despatie, which refers to the patient experience survey. This folder allows patients one spot to retain all their educational material received while an inpatient.

Q4 Continue as above.

Accountable: VP, Community Programs / Director, Quality and Risk

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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.

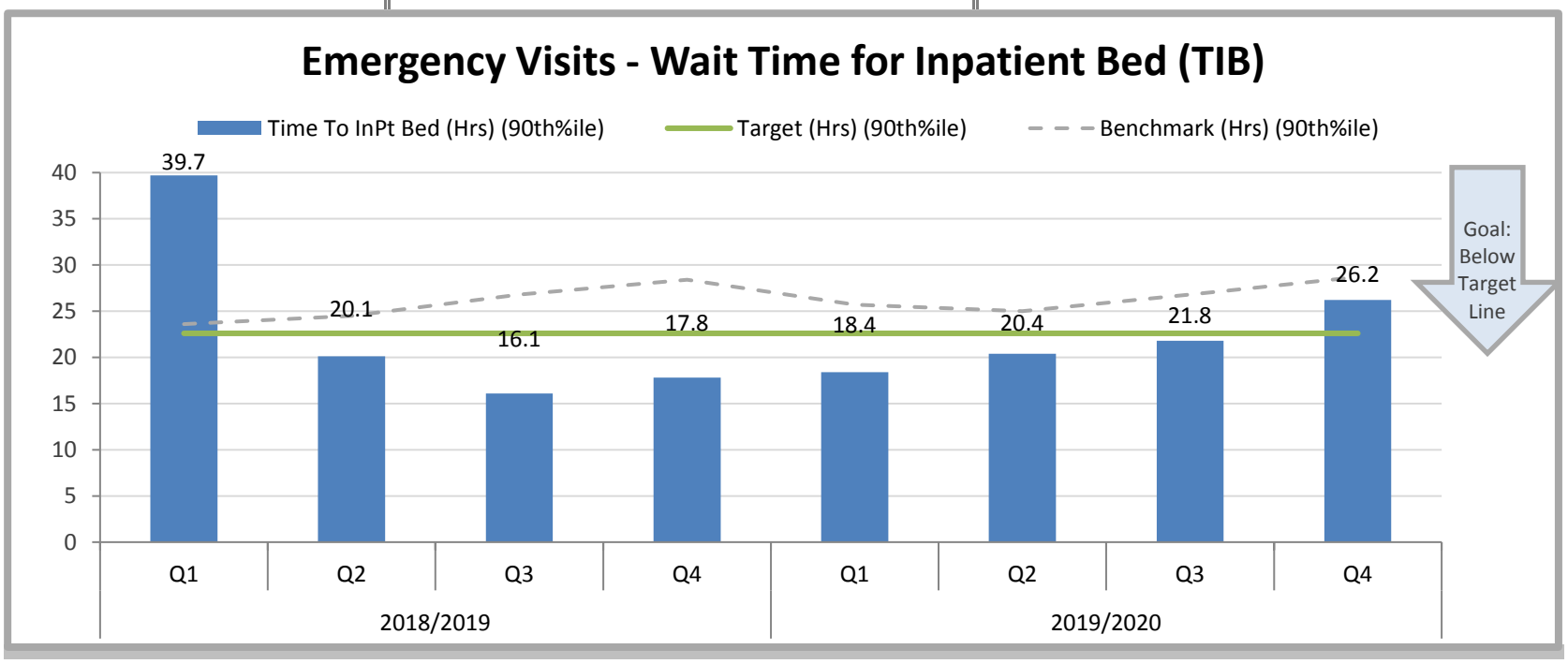
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the inpatient bed turnover rate and the total length of time admitted patients spend in the ED in an effort to improve the 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 FY1819 (Q1-Q3) performance of 23.8.
*Formula is 23.8 * (1 - 5%) =22.6

Benchmark Information: Benchmark performance is based on ATC ER Fiscal Year Report 'High-Volume Community Hospital Group' results. Benchmark results are presented as a year-to-date value.

	2018/2019				2019/2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To InPt Bed (Hrs) (90th%ile)	39.7	20.1	16.1	17.8	18.4	20.4	21.8	26.2
Benchmark (Hrs) (90th%ile)	23.6	24.5	26.8	28.4	25.7	25.0	26.8	28.7
Target (Hrs) (90th%ile)	22.6	22.6	22.6	22.6	22.6	22.6	22.6	22.6



Performance Analysis:

Q1 Target met and continues to trend well below benchmark high-volume hospitals.

Q2 Target met.

Q3 Target met.

Q4 Target not met. January and February experienced high occupancy rates at an average 109% for both months; this can be related to long length of stay and ALC volumes.

Plans for Improvement:

Q1 Performance is monitored and reviewed daily as part of resource meetings. Continued focus on identifying and managing barriers that may impede flow.

Q2 No plan required at this time. Target times on Daily Access Reporting Tool (DART) amended to focus on improving a.m. discharges.

Q3 Continue to focus on strategies to improve this metric.

Q4 Same as above. Current challenges include occupancy related to isolation of COVID19 suspect patients. All efforts are on monitoring isolation status and move patients from the ER to most appropriate beds on the inpatient units.

Accountable: VP, Patient Services and Chief Nursing Officer / Manager, Emergency Department

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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.

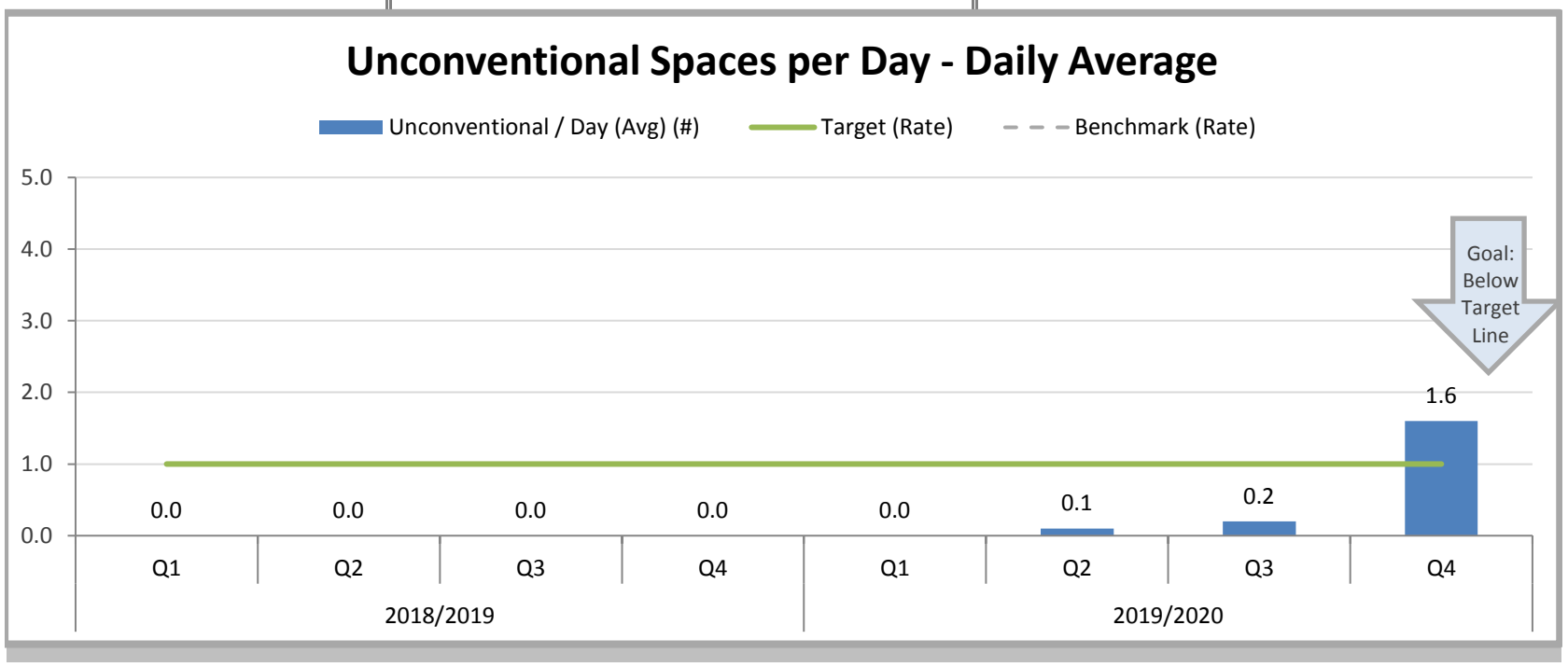
Significance: This indicator provides contextual information on the average number of patients who were admitted into hospitals receiving care in unconventional spaces during the third quarter, 2018/19. This may reflect seasonal surges. The indicator profiles the average number of beds over capacity 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

	2018/2019				2019/2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Unconventional / Day (Avg) (#)	0.0	0.0	0.0	0.0	0.0	0.1	0.2	1.6
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 for overall bed census count.

Q2 Target met for overall bed census count.

Q3 Target met for overall bed census count.

Q4 Target not met due to longer wait times to an inpatient bed, average ALC of 21 days, and high occupancy rates in January and February. Occupancy rate for both months averaged at 109%.

Plans for Improvement:

Q1 No plans for improvement at this time.

Q2 Continue monitoring. No plans for improvement at this time.

Q3 Continue monitoring. No plans for improvement at this time.

Q4 Processes have been implemented during the last month of this quarter to prevent any patients from being admitted in unconventional spaces. Working in increasing inpatient bed capacity to prevent any utilization of unconventional beds for admitted patients.

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

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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).

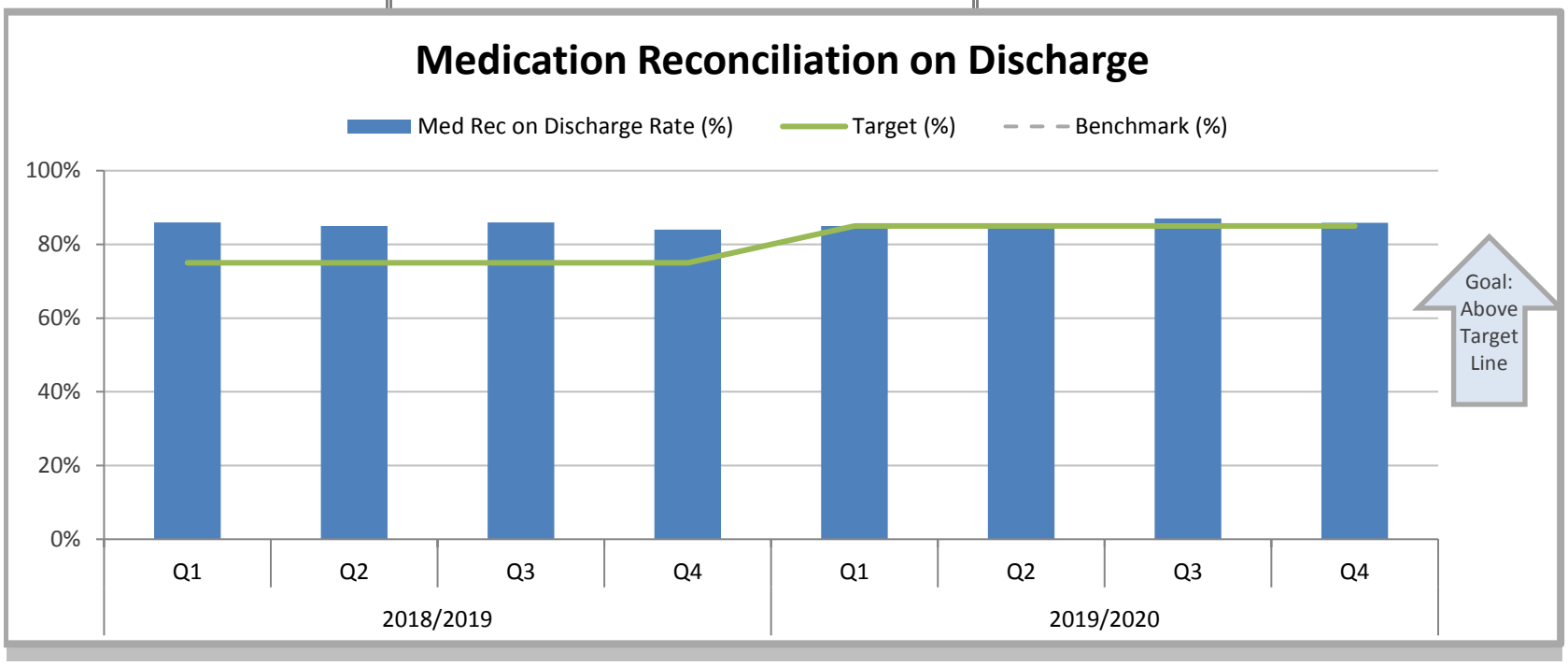
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a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

	2018/2019				2019/2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)	86%	85%	86%	84%	85%	85%	87%	86%
Benchmark (%)								
Target (%)	75%	75%	75%	75%	85%	85%	85%	85%



Performance Analysis:

Q1 Target met and continues to trend around 85%. Breakdown by department shows CCU and Mental Health below target at 51% and 73%. All other departments are well within suggested target.

Q2 Target met. Breakdown by department shows a slight improvement in CCU with rate of 53%. Mental Health department has shown a tremendous improvement with rate currently being 82%, sitting just below suggested target.

Q3 Target met. Slight improvement overall except for CCU decreasing to 45%. Mental Health department has shown improvement and currently above suggested target.

Q4 Target met. CCU decreased to 36.8% and Mental Health just shy of target at 84.7%.

Plans for Improvement:

Q1 To communicate results to IPMH and CCU. Discuss barriers with the groups.

Q2 Continue as above.

Q3 Continue as above.

Q4 Continue as above.

Accountable: Chief Information 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. Results are cumulative year-to-date. Awareness created in FY2018-19, the goal for 2019-20 will be to have less incidents.

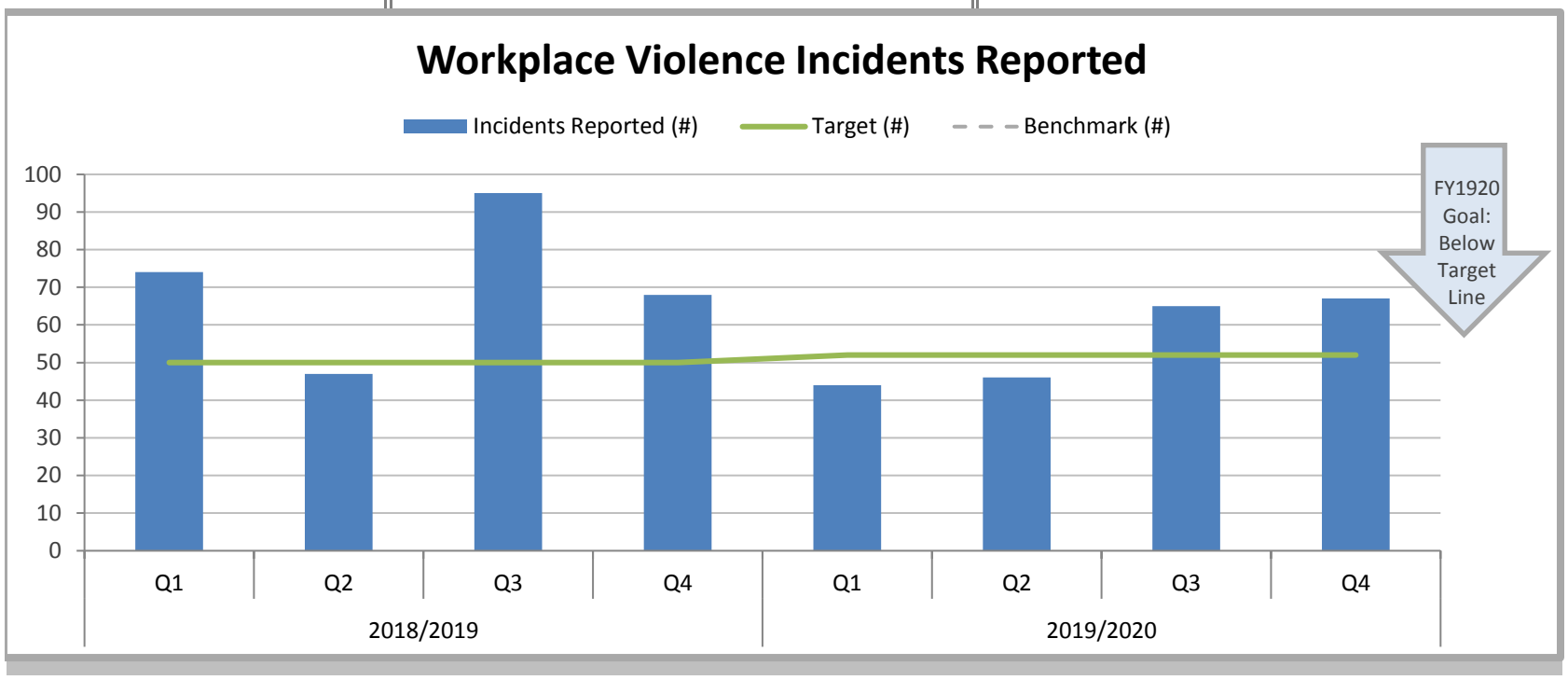
Significance: Workplace violence is defined by the Occupational Health and Safety Act as the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker. Violence in the workplace is an increasingly serious occupational hazard. Like 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

	2018/2019				2019/2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Incidents Reported (#)	74	47	95	68	44	46	65	67
Benchmark (#)								
Target (#)	50	50	50	50	52	52	52	52



Performance Analysis:

Q1 Target met. The focus for FY1920 is to have less incidents reported.

Q2 Target met.

Q3 Target not met. Children's Day Treatment incident reporting started as of September. Of the 65 incidents reported in Q3, 19 incidents occurred in Children's Day Treatment increasing the incidence rate by 29%.

Q4 Target not met. Of the 77 incidents reported in Q4, 27 incidents occurred in Medicine, with an incidence rate of 35%.

Plans for Improvement:

Q1 Continue to increase awareness around violence prevention and training (e.g., NVCI training and Pulse articles).

Q2 Strong understanding of incident reporting understood by staff.

Q3 High proportion of incidents related to Children's Day Treatment. Suggest adjusting benchmark moving forward to take this into account.

Q4 High proportion of incidents related to addition of incidents from Children's Day Treatment.

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

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