Cornwall Community Hospital
Hôpital communautaire de Cornwal

QUALITY IMPROVEMENT PLAN SCORECARD 2017/2018

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: Overall Rating	QIP/SIA	Y	Y	G	N/A
Patient Experience Survey: Information	QIP/SIA	Y	Y	G	N/A
Readmission Rate for (QBP) COPD	QIP/SIA	R	G	R	G

PARTNERING FOR PATIENT SAFETY AND QUALITY OUTCOMES

Indicator	Reference	Q1	Q2	Q3	Q4
Emergency Visits - Left Without Being Seen (LWBS)	QIP/SIA/MoHLTC	R	R	R	R
ROP - Medication Reconciliation on Admission Rate	QIP/SIA/Accreditation	R	R	R	R
ROP - Medication Reconciliation on Discharge Rate	QIP/SIA/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

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

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

QIP - Quality Improvement Plan

SIA - Strategy in Action

QUALITY IMPROVEMENT PLAN 2017/2018

Return to Dashboard

Indicator: Patient Experience Survey

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: Percentage of respondents who responded positively (rating of 6-10) to “Overall, how would you rate the care you received?” (Question #21).

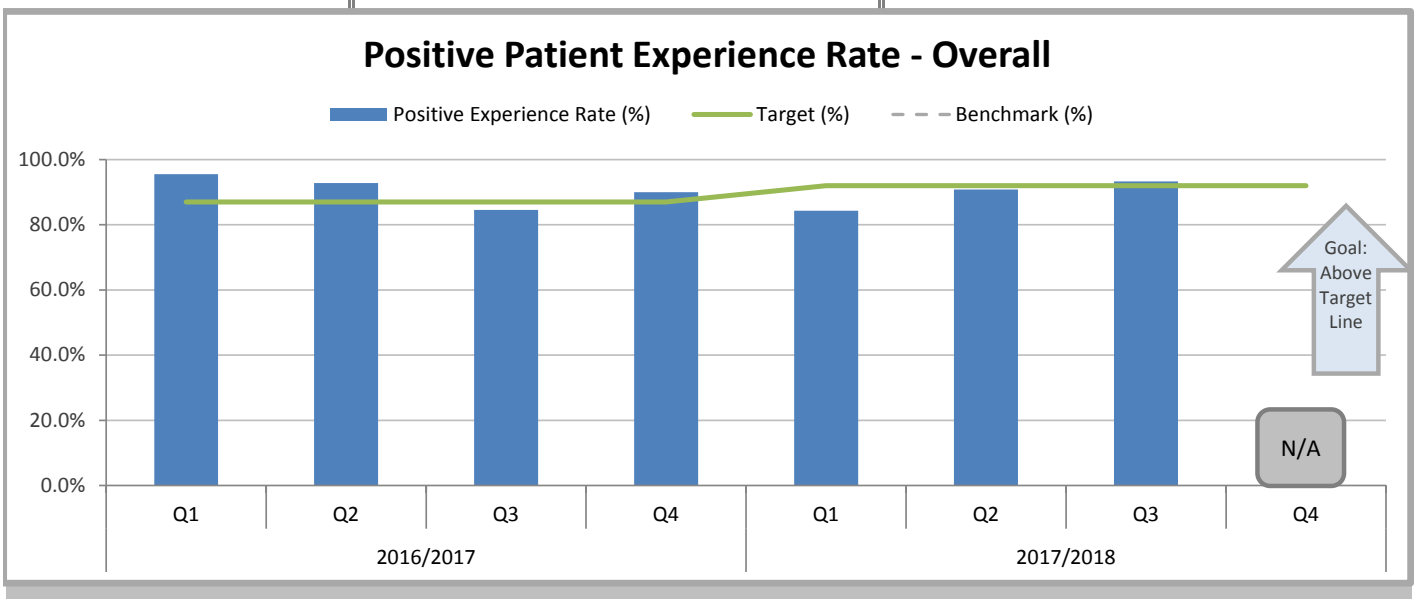
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians’ experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: Internal Survey Results

Target Information: Set in accordance to QIP indicator

Benchmark Information: N/A

	2016/2017				2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	95.5%	92.8%	84.6%	90.0%	84.3%	90.8%	93.3%	N/A
Benchmark (%)								
Target (%)	87.0%	87.0%	87.0%	87.0%	92.0%	92.0%	92.0%	92.0%



Performance Analysis:

Q1 Q4 16/17 Results (Quarterly results are available one quarter behind) - Results exceeding target

Q2 Q1 results - Just below target. There were 140 applicable returns.

Q3 Q2 results - Just below target. Sample size was 130 responders which is on the low side.

Q4 Q3 results - Slightly exceeding target. Sample size was 194 responders which is increased. Q4 results not available at this time.

Plans for Improvement:

Q1 Plans for improvement in 17/18 include "Patient Experience" and Indigenous Cultural Training for staff, increased volunteer utilization, exploring a new TV/IPad program, and noise level awareness.

Q2 To help influence overall results, some areas have developed their own questionnaires to obtain more relevant feedback.

Q3 Same as above.

Q4 As of April 1 2018, the Hospital has signed with NRC for our Inpatient and Emergency Department Surveys. The survey tool being used by NRC is consistent with peers and we anticipate improved turn around time.

Accountable: VP Patient Services and CNO / Patient Relations Specialist

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Return to Dashboard

Indicator: Patient Experience Survey

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: Percentage of respondents who responded positively (positive responses include "completely" and "quite a bit") 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?" (#38)

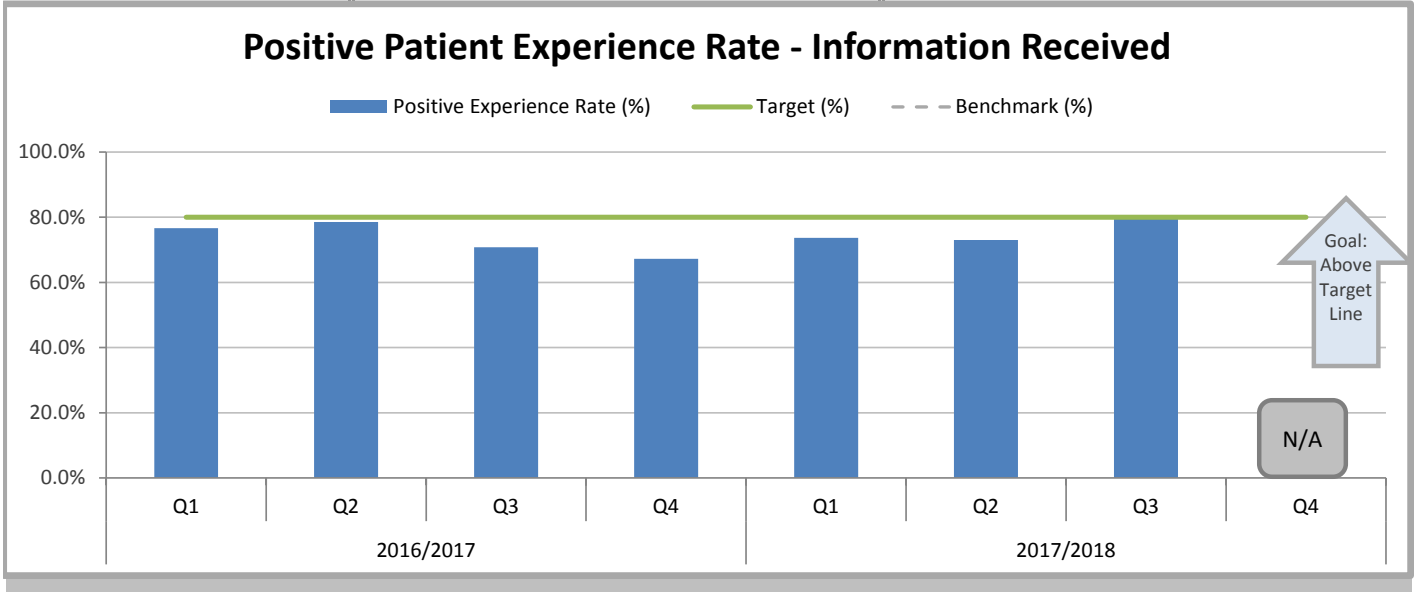
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that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

Data Source: Internal Survey Results

Target Information: Set in accordance to QIP indicator

Benchmark Information: N/A

	2016/2017				2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	76.6%	78.5%	70.8%	67.2%	73.7%	73.0%	80.4%	N/A
Benchmark (%)								
Target (%)	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%



Performance Analysis:

Q1 Q4 16/17 Results (Quarterly results are available one quarter behind) - Results are below target

Q2 Q1 results are trending below target. There were only 133 applicable returns.

Q3 Q2 results are slightly down with only 126 respondents.

Q4 Q3 results are above target with an increase of respondent returns to 179.

Plans for Improvement:

Q1 Healthwise has been identified as potential software to provide information on the top 10 Case Mix Group (CMG) cases for patients. In addition , patient educational handbooks are being developed for the top 3 most common admitting diagnosis by inpatient department.

Q2 The CI (FHIT) team continues to focus on the quality of patient discharge summaries. The Director of Professional Practice continues the work on patient information handbooks relevant to the reason for their admission.

Q3 Identified as one of the organization top priorities for FY2018-19.

Q4 Continue above plans. As of April 1 2018, the Hospital has signed with NRC for our Inpatient surveys Emergency Department Surveys. The survey tool being proposed is consistent with peers and it is anticipated that turn around time in receiving the data will be improved.

Accountable: VP Patient Services and CNO / Patient Relations Specialist

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Indicator: Readmission Rate for (QBP) COPD

Strategic Direction: Patient Inspired Care

Definition: The measuring unit of this indicator is an admission for chronic obstructive pulmonary disease (COPD), as defined for the QBP. Results are expressed as the number of COPD patients (QBP defined) readmitted with same or related diagnosis within 28-days of discharge. Overall QBP criteria includes; most responsible diagnosis of COPD, Ontario resident, valid Health Care Number, and Age >=35. Readmissions include non-elective admissions.

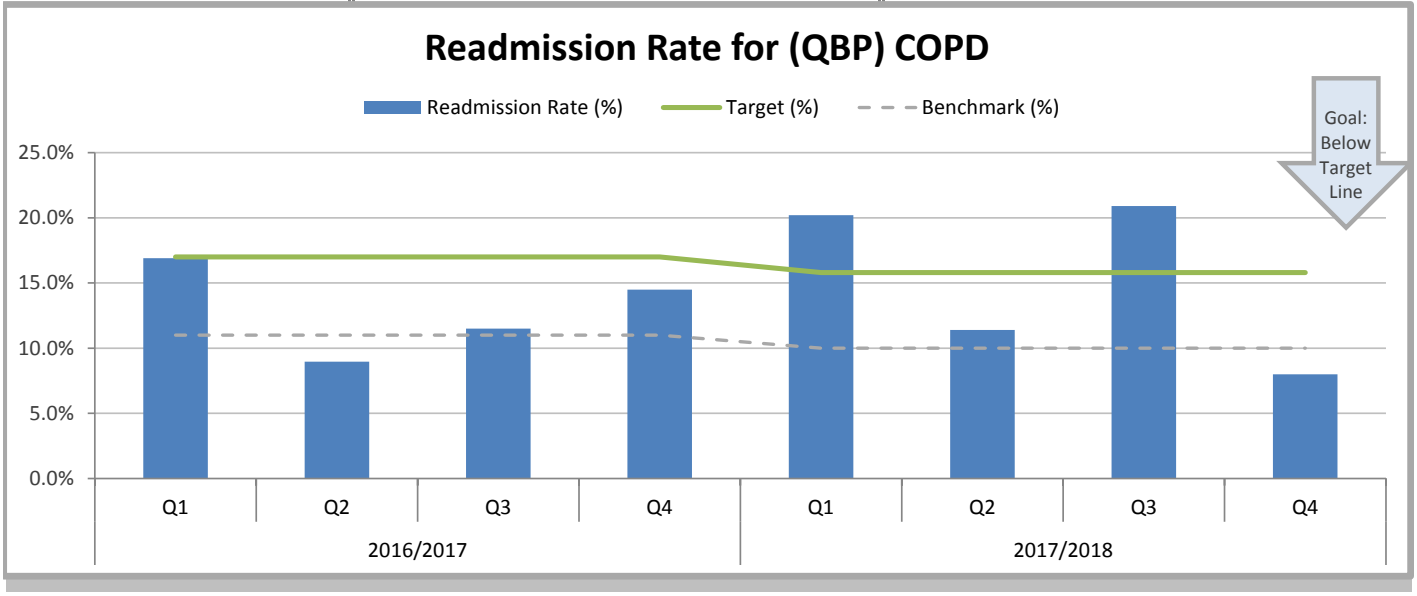
Significance: Unplanned hospital readmissions exact a toll on individuals, families and the health system. Avoidable readmissions remain a system-level issue that is also linked to integration among providers across the continuum of care. If patients get the care they need when and where they need it,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

Data Source: DAD (Discharge Abstract Database)

Target Information: Target is set internally at 15.8 (5% decrease from average of last four quarters); to align with Quality Improvement Plan (QIP) metric

Benchmark Information: Benchmark performance is based on our Peer (20) Hospital prior year performance

	2016/2017				2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	16.9%	9.0%	11.5%	14.5%	20.2%	11.4%	20.9%	8.0%
Benchmark (%)	11.0%	11.0%	11.0%	11.0%	10.0%	10.0%	10.0%	10.0%
Target (%)	17.0%	17.0%	17.0%	17.0%	15.8%	15.8%	15.8%	15.8%



Performance Analysis:

Q1 Preliminary numbers (estimates) based on Cerner information results in a readmission rate of 20.4% for Q1.

Q2 Q2 performance improved over Q1 and trending below target of 15%. Prior year data however shows a 3.9% increase for the same quarter.

Q3 Results for Q3 are not available at this time. We will report Q3 results at Q4 when coding and abstracting have been completed.

Q4 Q4 results below target; marked improvement over Q3. Average rate for FY17/8 is 15%. Overall improvement at year end 2017/18 compared to prior year end 2016/17.

Plans for Improvement:

Q1 Continued work by the working group and establishing referral patterns with Seaway Valley (SV) Health Clinic.

Q2 Ongoing partnership with SV Clinic. Improvements include: physician education planned; implementation of a central intake process for referrals and standardized referral form for primary care providers; electronic referral process for CCH providers; and implementation of COPD order sets highlighting Quality Based Procedure best practices.

Q3 Work described above continues. The use of the ordersets has increased.

Q4 Work will continue as per Q3. Collaboration with SV Clinic will continue and plans to further support the inpatient population will be the goal. Regular review of order set usage will continue.

Accountable: VP Patient Services and CNO

QUALITY IMPROVEMENT PLAN 2017/2018

Return to Dashboard

Indicator: Percentage Emergency Visits Left Without Being Seen (LWBS)

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: The total number of visits to the Emergency Department where the patient left without being seen by a physician following registration (initial assessment/treatment did not occur) compared to the total number of unscheduled Emergency Department visits. Calculated by dividing the number of patients with a visit disposition of code 02 or 03 by the total number of unscheduled Emergency visits. Performance is cumulative.

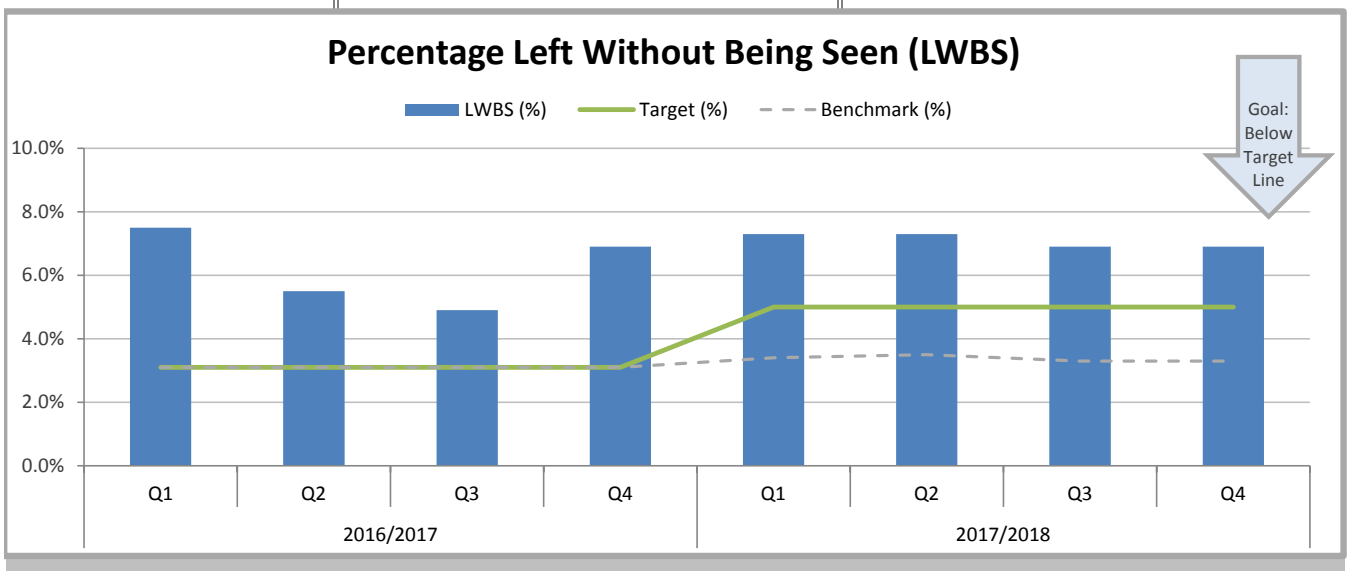
Significance: Patients who leave without being seen (LWBS) can be an indicator of patient satisfaction and quality for emergency departments (ED). Regardless of the cause—be it longer wait times, increased visits, or decreased supply—patients who leave the ED without being seen signal that access-to-care issues are prevalent.

Data Source: Access to Care - Fiscal Year Report - % Left Without Being Seen

Target Information: Target is based on a 15% decrease from average of last four quarters

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.

	2016/2017				2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
LWBS (%)	7.5%	5.5%	4.9%	6.9%	7.3%	7.3%	6.9%	6.9%
Benchmark (%)	3.1%	3.1%	3.1%	3.1%	3.4%	3.5%	3.3%	3.3%
Target (%)	3.1%	3.1%	3.1%	3.1%	5.0%	5.0%	5.0%	5.0%



Performance Analysis:

Q1 Increase from Q2-Q4 last fiscal year. Lower than Q1 from last fiscal year.

Q2 Same results as last quarter.

Q3 Slight decrease in LWBS

Q4 Same as previous quarter.

Plans for Improvement:

Q1 RPN hours in the ED modified to keep See and Treat open 24 hours per day starting July 2017. This improves flow of patients in the evening. Physician shift has been modified to move hours from day to later in the evening starting July 1st. An analysis has been done after 2 months, and this change has not demonstrated any improvement in LWBS or PIA. Discussion amongst emergency physicians to modify slightly this shift. A continuous improvement project has been initiated to modify flow of See and Treat by implementing a "Fast Track" in See and Treat. The team is currently working on the implementation of this Fast Track as a first priority, then will be looking at other opportunities to improve flow of non-admitted patients in the ED.

Q2 Continue as above.

Q3 Fast Track was implemented in December. Continue with Fast Track. Implement structured nurse rounding in the ED waiting room in March 2018.

Q4 Waiting Room rounds have not been initiated. A call back process for patients who LWBS has been implemented. Initial report demonstrates that most patients who leave without being seen leave because of the wait times. LWBS is a mini project imbedded within the ED corporate projects. One of the initiatives to be implemented is the re-instatement of the volunteer program in the ED. Although the Fast Track project did not show a marked decrease in the number of patients who leave without being seen, the decision has been made by the ED physicians and nurses to continue with the Fast Track project for another 6 months and re-evaluate at that time.

Accountable: Senior Director Critical Care and Perioperative Services / Director Medical Services

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

Strategic Direction: Excellence in Quality, Patient Safety, & Service Delivery

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 admitted patients with completed Medication Reconciliation divided by the total # of admitted patients. (Excludes - Obstetrical and Newborn patients).

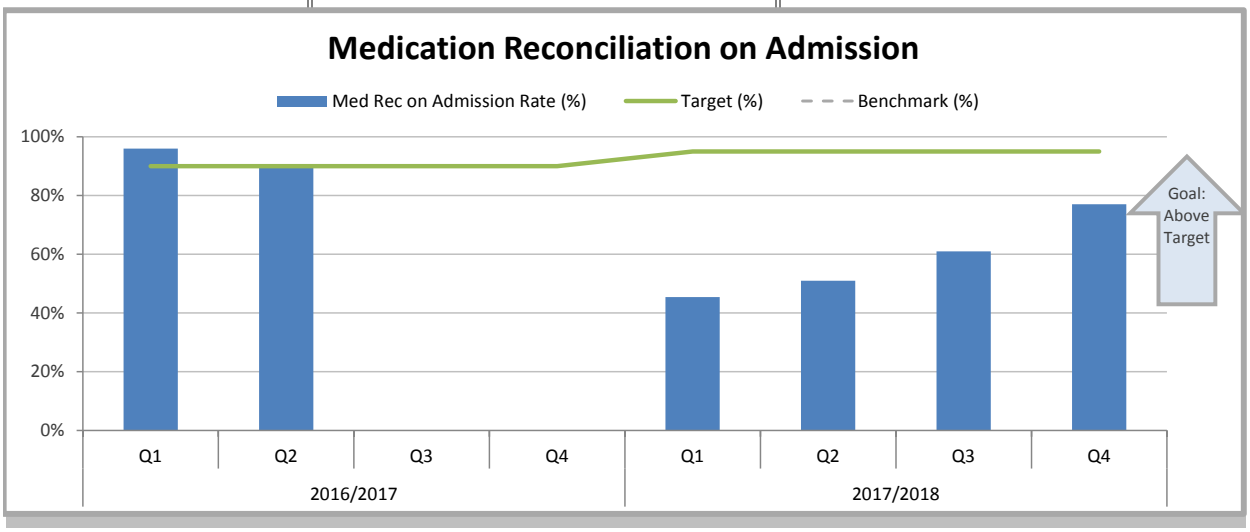
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a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

Benchmark Information: N/A

	2016/2017				2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Admission Rate (%)	96%	90%	N/A	N/A	45%	51%	61%	77%
Benchmark (%)								
Target (%)	90%	90%	90%	90%	95%	95%	95%	95%



Performance Analysis:

Q1 -Process has completely changed with the introduction of the electronic health record. This will improve. The best possible medication history is being obtained and provided for the majority of patients admitted through emergency.

Q2 -Q2 results have improved slightly but continue well below target.

Q3 -Continuous improvement over the last couple quarters, improvement is coming from education and efficiencies from MedRec techs mostly.

Q4
-Successful extension of MedRec tech hours until midnight 7 days a week.
-Rule built in system and rolled out in multiple areas.
-Obvious improvement over last quarter with rule roll out, hour extension and physicians' MedRec education.
-Obvious month over month progress 75% Jan, 78% Feb, 80% March.

Plans for Improvement:

Q1 Continued work with the CI2 team and the emergency working group to formalize a process.

Q2
-Continue with physician's education, highlighting the importance of completing MedRec as a very high percentage (30%) are done partially.
-Discuss with Chief of staff and at various Department meetings.
-Build a system rule within Cerner to alert providers to finish MedRec.

Q3
-Continue with raising awareness for different physician groups
-MedRec techs hours extension until 12pm 7 days/week, addition of extra tech on weekends to facilitate having BPMH before admission
-Building a rule in the system to force function having admission MedRec ready
-CI initiative started with MedRec techs to improve on their workflows and facilitate the process
-Work with the Champlain regional pharmacist community to enhance communication back and forth between hospital and community pharmacies

Q4
-Continuous improvement work with MedRec techs to improve efficiency for timely BPMH.
-Expansion of existing rule built in system to be rolled out institution wide.
-On right path for achieving 90% for 2018-2019 year, especially with hospital wide rule rollout.

Accountable: VP Patient Services and Chief Nursing Officer / Chief of Staff

QUALITY IMPROVEMENT PLAN 2017/2018

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

Strategic Direction: Excellence in Quality, Patient Safety, & Service Delivery

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).

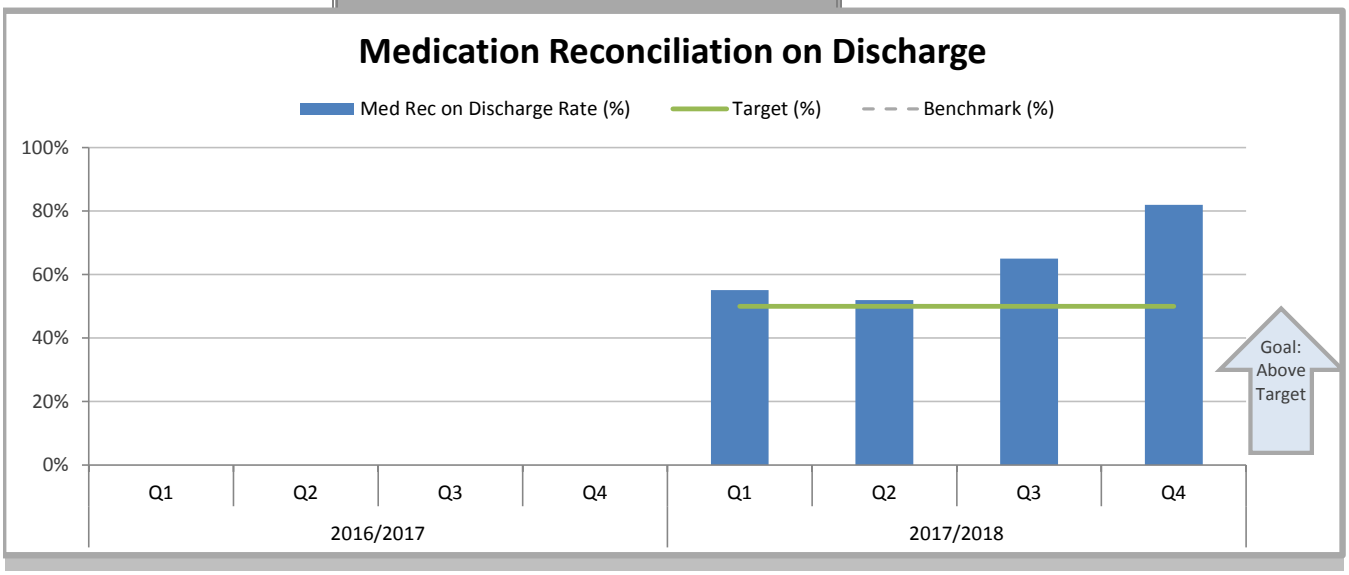
Significance: Medication reconciliation is a formal process in which healthcare providers work together with patients, families and care providers to ensure accurate and comprehensive medication information is communicated consistently across transitions of care. Medication reconciliation requires a 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 50%

Benchmark Information: N/A

	2016/2017				2017/2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Rec on Discharge Rate (%)					55%	52%	65%	82%
Benchmark (%)								
Target (%)					50%	50%	50%	50%



Performance Analysis:

Q1 -The data quality remains challenging.

Q2 -Trending slightly above and within target.

Q3 -Continuous improvement over the last couple quarters, improvement is coming from education and efficiencies from MedRec techs mostly.

Q4
-Rule built in system and is being rolled out in multiple areas.
-Obvious improvement over last quarter with rule roll out and MedRec education.
-Obvious month over month progress 81% Jan, 82% Feb, 83% March.
-On right path for achieving 90% for 2018-2019 year, especially with hospital wide rule rollout.

Plans for Improvement:

Q1 -This is a priority for the AMS and FHIT leadership team to improve the data quality and patient safety.

Q2 -The CI (FHIT) team is focusing on enhancing the Patient Discharge summary that will incorporate medication reconciliation information.

Q3
-Continue with raising awareness for different physician groups.
-Building a rule in the system to force function having Discharge MedRec ready.
-Work with the Champlain regional pharmacist community to enhance communication back and forth between hospital and community pharmacies.

Q4
-Expansion of existing rule built in system to be rolled out institution wide.
-On right path for achieving 90% for 2018-2019 year, especially with hospital wide rule rollout with Champlain regional pharmacy committee on ideas to enhance communication with patients own pharmacies.
-In planning phase for some improvement ideas.

Accountable: VP Patient Services and Chief Nursing Officer / Chief of Staff

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Hôpital communautaire de Cornwall

MISSION:
Our health care team collaborates to provide exceptional patient centered care

Strategic Plan 2016-2021

Cornwall Community Hospital
Hôpital communautaire de Cornwall

MISSION :
Notre équipe de soins collabore en vue de dispenser des soins exceptionnels, axés sur les patients.

Orientations stratégiques 2016-2021

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