Cornwall Community Hospital
Hôpital communautaire de Cornwal

QUALITY IMPROVEMENT PLAN 2016/2017

Vision: Exceptional Care. Always.

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

Values: *I C A R E   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**
ALC Rate	HSAA/QIP	G	R	Y	
Readmission Rate for (QBP) COPD	QIP	G	G	G	

PARTNERING FOR PATIENT SAFETY AND QUALITY OUTCOMES					
Indicator	**Reference**	**Q1**	**Q2**	**Q3**	**Q4**
Emergency Visits - Length of Stay for Admitted Patients	HSAA/QIP	R	R	R	
Positive Patient Experience	QIP	G	G	N/A	
ROP - Medication Reconciliation on Admission Rate	QIP/Accreditation	G	G	N/A	
Surgical Safety Checklist Rate	QIP	Y	Y	G	
Clostridium Difficile Incidence	MoHLTC/HSAA/QIP	Y	R	R	
Ventilator Acquired Pneumonia	MoHLTC/HSAA/QIP	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

Indicator: ALC Rate

Strategic Direction: Patient Inspired Care

Definition: The percentage of inpatient days where a physician (or designated other) has indicated that a patient occupying an acute care hospital bed has finished the acute care phase of his/her treatment.   The calculation is the total number of inpatient days designated as ALC for patients in acute beds discharged in a given time period divided by the total number of acute inpatient days in a given time period x 100. (Includes Pediatric 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: Numerator Data Source from Cancer Care Ontario-Wait Time - ALC data; Denominator Data Source from Bed Census Summary (General Ledger) - Inpatient Days

Target Information: Target rate is standardized according to HSAA specifications

Benchmark Information: Benchmark performance is based on ATC iPort - Champlain LHIN prior fiscal year performance

	2015/2016				2016/2017			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
ALC Days (%)	17.0%	12.7%	17.3%	14.9%	11.1%	15.3%	13.0%	
Benchmark (%)	12.4%	12.4%	12.4%	12.4%	12.6%	12.6%	12.6%	12.6%
Target (%)	18.0%	18.0%	18.0%	18.0%	12.7%	12.7%	12.7%	12.7%

Percentage of ALC Days
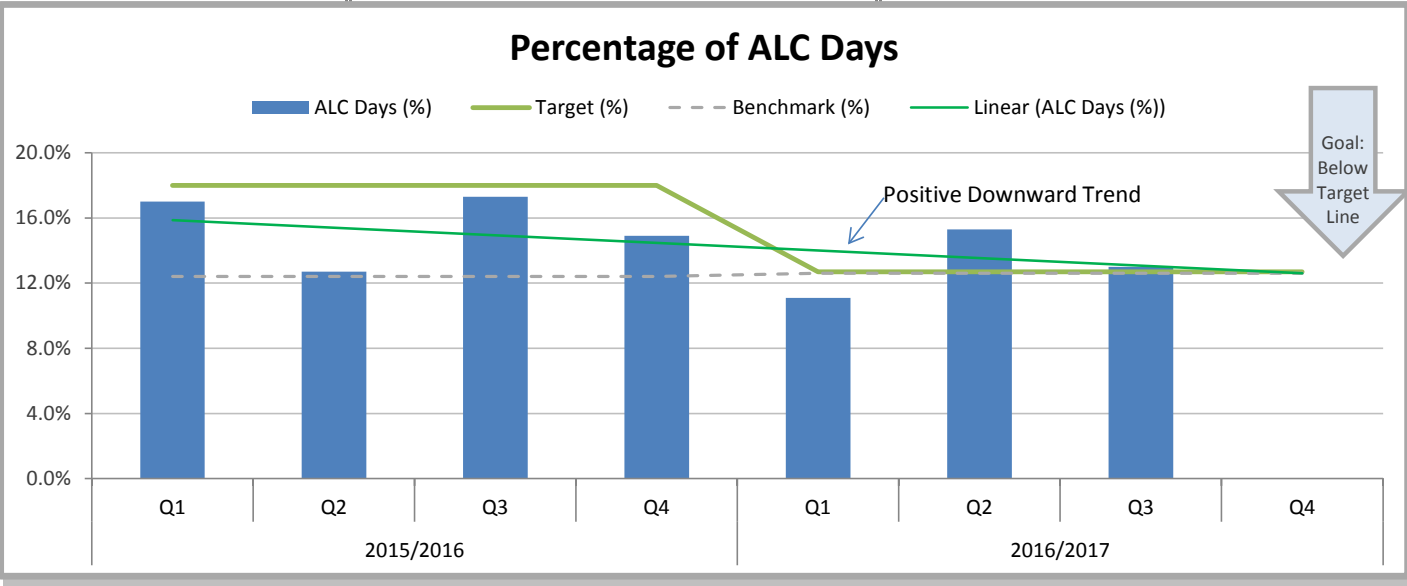
Performance Analysis:

Q1   CCH performance meeting target.

Q2   The higher number of ALC days is related to discharge of some long stay patients during the quarter.

Q3   Performance based on October and November data only, given conversion to Cerner December 1st. Some ALC days are associated with CCAC waitlists for personal support services and specialized treatments.

Q4

Plans for Improvement:

Q1   Continue all current strategies.

Q2   Continue all current strategies.

Q3   Continue to work closely with CCAC and the Champlain LHIN to minimize the delays associated with service waitlisting.

Q4

Accountable: VP Patient Services and CNO / Director Community Liaison and Patient Access

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 17.0%; in accordance to Quality Improvement Plan (QIP) metric

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

	2015/2016				2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Readmission Rate (%)	17.9%	23.1%	15.8%	11.0%	16.9%	9.0%	11.5%	
Benchmark (%)	9.4%	9.4%	9.4%	9.4%	11.0%	11.0%	11.0%	11.0%
Target (%)	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%	17.0%

Readmission Rate for (QBP) COPD
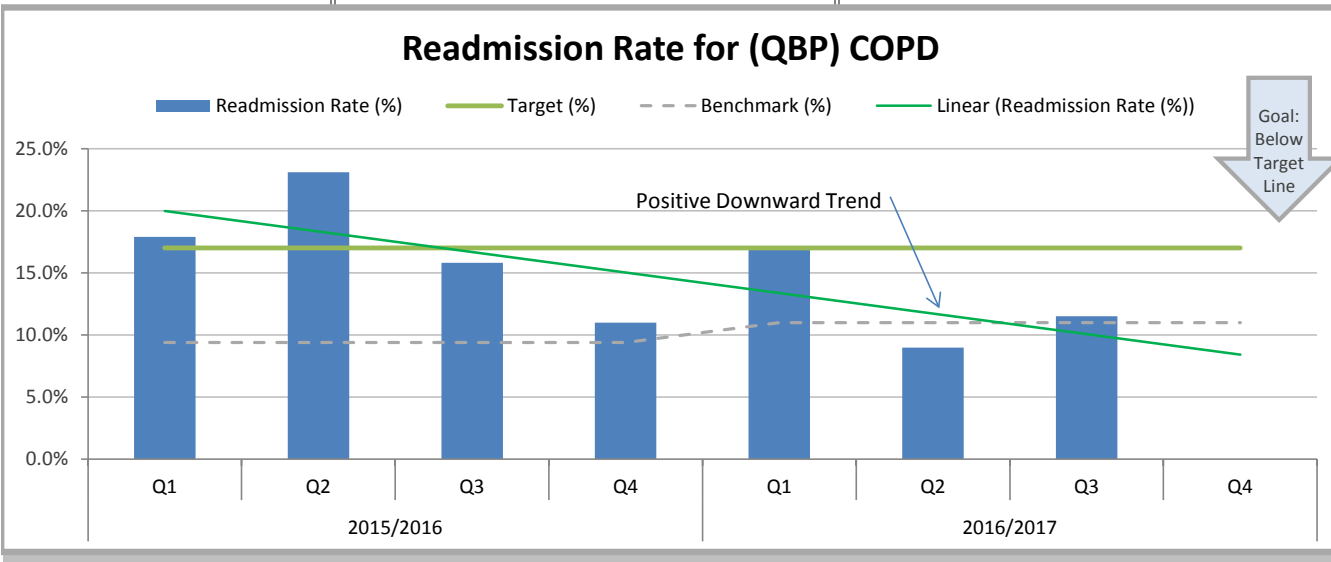
Performance Analysis:

Q1 CCH performance meeting target.

Q2 Performance meeting target.

Q3 Slight increase in readmission rate from Q2. Due to the instability of the monthly rates and the low volumes of December abstracts completed at the time of scorecard submission, performance is based on October and November data only.

Q4

Plans for Improvement:

Q1 Continue all current strategies.

Q2 Work is ongoing with community programs (Seaway Valley) who have received funding to reduce readmissions. With Cerner we will also be able to monitor the number of physicians using best practice guidleines, ie. use of the standard ordersets for COPD. Further action can be taken when this data is available.

Q3 Continue current plans.

Q4

Accountable: VP Patient Services and CNO

Indicator: Emergency Department Length of Stay for Admitted Patients

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: Using Pay-for-Results program indicator for admitted patients which is based on the 90th percentile ER length of stay. Time calculated from Triage time to time patient left ED for admitted patients only. This indicator coupled with Time to Inpatient Bed give a clear picture of the admitted patients entire length of stay in the Emergency Department.

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 total length of time admitted patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. (CIHI - Indicator Metadata)

Data Source: Access to Care Emergency Room Fiscal Year Report (ERNI)

Target Information: Based on HSAA specifications

Benchmark Information: Based on the ATC "High-Volume Community Hospital Group"

	2015/2016				2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
ED LOS -Admitted (90%ile-Hours)	32.7	25.0	30.1	44.2	50.0	39.6	47.7	
Benchmark (90%ile-Hours)	29.1	27.3	28.8	30.8	31.2	31.5	34.0	
Target (90%ile-Hours)	35.0	35.0	35.0	35.0	35.0	35.0	35.0	35.0

ED Length of Stay for Admitted Patients
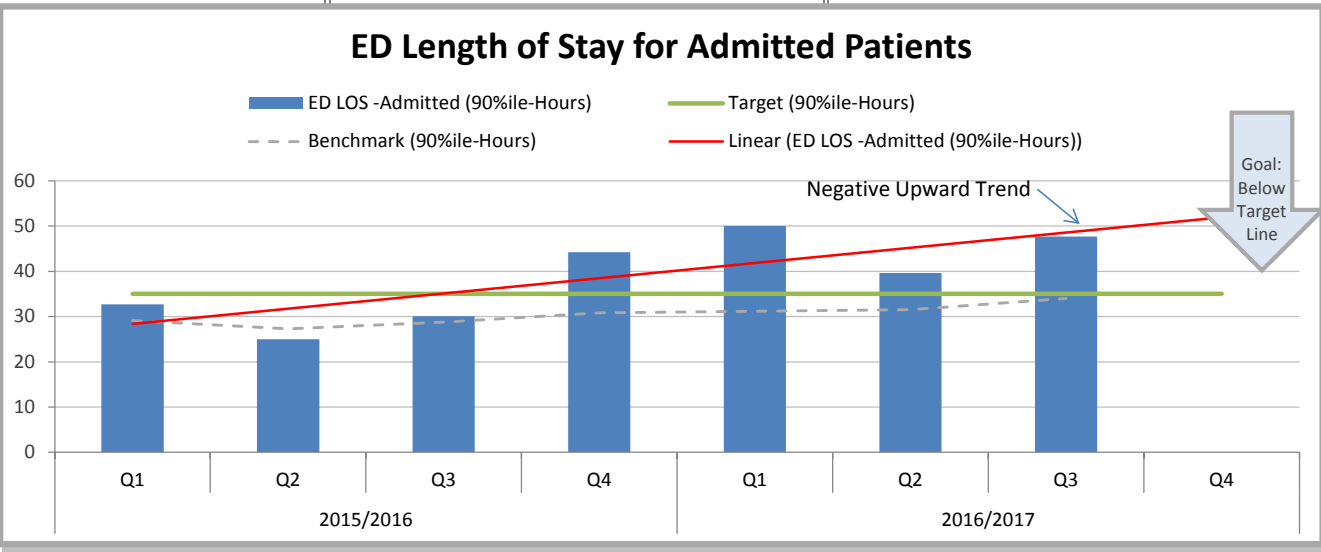
Performance Analysis:

Q1 Increase occupancy, including a large number of ALC patients, in Q1 resulted in admitted patients staying in the ED for a long period of time.

Q2 Goal not achieved however, a decrease by 10 hours occurred over Q1. Increased occupancy and high ALC numbers continue to impact patient flow.

Q3 Target not met. Ongoing challenges with occupancy through Q3. High levels of ALC continue. Patient flow impacted as a result of these challenges.

Q4

Plans for Improvement:

Q1 On-going discussions with the Champlain LHIN on occupancy. Ongoing and successful collaboration with Glengarry Memorial Hospital to repatriate patients. Resource rounds occurring 3 times daily. Continuous discussions with physicians in improving patient flow.

Q2 Continue plan as Q1. Ongoing efforts and collaboration with physicians to support discharge are a priority. Weekly discharge review of patients with key stakeholders occurs; daily Bullet Rounds and Bi-Weekly Physician rounds continue (proposed plan to increase to 3/week). As a means of reducing conservable days, a Length of Stay report will be provided in the new year to the Department Chief's, for their follow up with specific physicians.

Q3 Continue plan as per Q2. Additional strategies are underway to support patient flow initiatives. A patient flow support person will be trialed to support transitions from the ED to the inpatient units.

Q4

Accountable: VP Patient Services and CNO / Director Medical Services

Indicator: Positive Patient Experience

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

	2015/2016				2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Positive Experience Rate (%)	89.6%	88.5%	89.1%	93.8%	95.5%	92.8%		
Benchmark (%)								
Target (%)	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%	87.0%
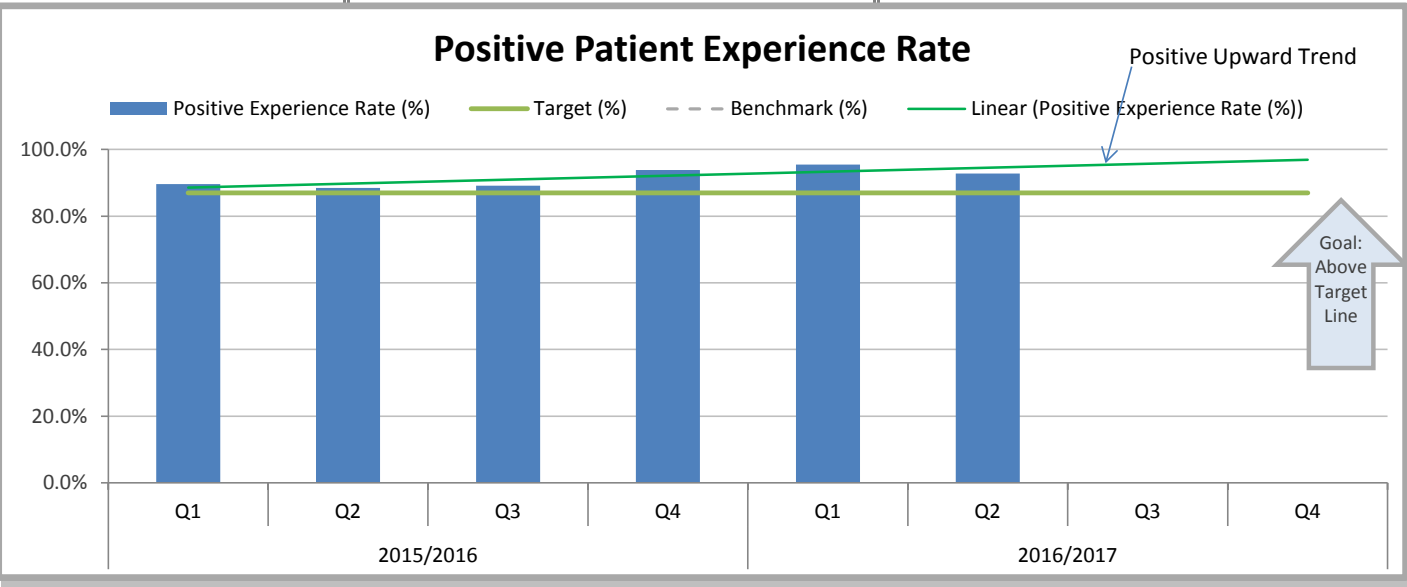
Performance Analysis:

Q1 Q1 data not available at this time.

Q2 Q1 Results - Exceeding target, Q1 - 110 responses

Q3 Exceeding target , Q2 - 166 responses out of 630 surveys sent.

Q4

Plans for Improvement:

Q1 Quarterly results are available one quarter behind; Q1 data will be added for Q2 review.

Q2 Q1 Results - To influence overall results, the top and bottom 3 quarterly patient survey results are shared with Directors/Managers, and they are working on improving one of the bottom 3 results.

Q3 Same strategy as Q2.

Q4

Accountable: VP Operation / Patient Relations Specialist

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.

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: Internal audit and tracking

Target Information: Set internally

Benchmark Information: N/A

	2015/2016				2016/2017			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
Med Rec on Admission Rate (%)	97%	98%	98%	95%	96%	90%	N/A	
Benchmark (%)								
Target (%)	90%	90%	90%	90%	90%	90%	90%	90%

Medication Reconciliation on Admission
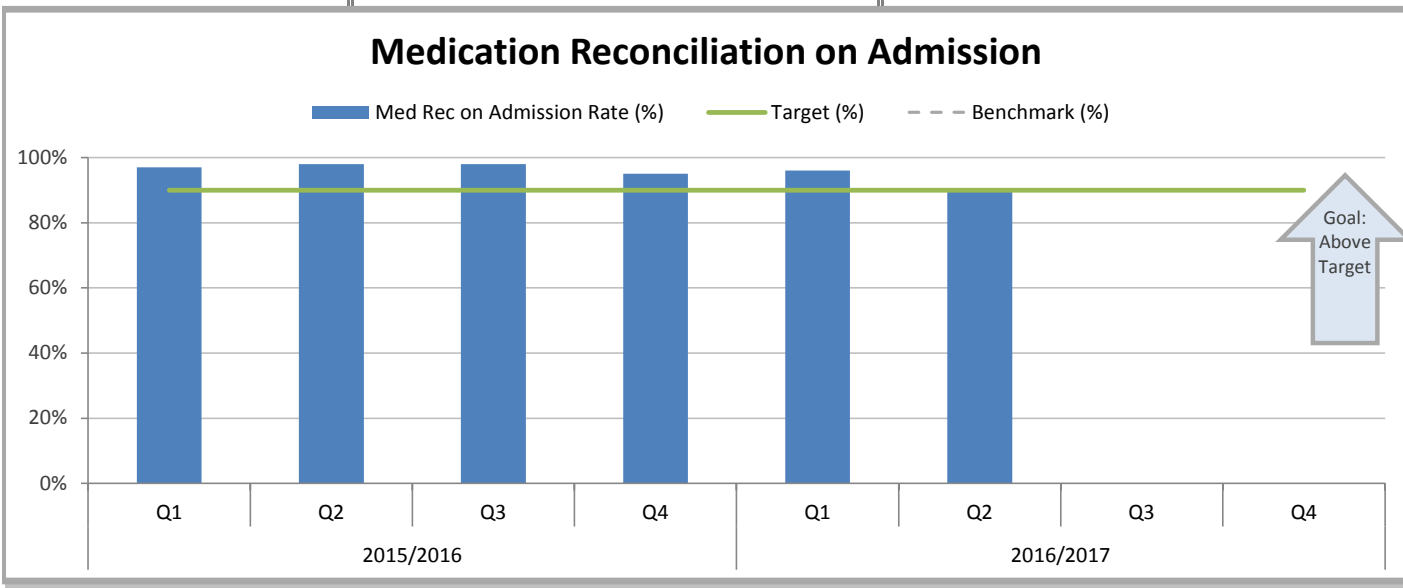
Performance Analysis:

Q1 Performance exceeds target.

Q2 This quarter is calculated using July and August only. September not available as of November 22nd.

Q3 Results for Q3 are not available at this time. The implementation of the EHR has presented some complexities in accessing performance data in this area.

Q4

Plans for Improvement:

Q1 Continue focus and auditing to ensure targets are met.

Q2 Efficiencies from implementing Cerner will allow for easier medication reconciliation for physicians.

Q3 Planning education for staff and physicians, and reviewing process post-EHR implementation.

Q4

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

Indicator: Surgical Safety Checklist Rate

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: Surgical Safety Checklist is a tool used by the surgical team to increase communication among members, in turn creating a safer environment for the patient. The surgical checklist is used to "ensure that the preoperative, intraoperative and postoperative steps that have been shown to benefit patients are undertaken in a timely and efficient way" (WHO Brochure, Safe Surgery Saves Lives).

Significance: As of 2011 Accreditation Canada has introduced the use of a Safe Surgery Checklist as a Required Organizational Practice. The surgical team must use a checklist to ensure proper steps are followed prior to the procedure.

Data Source: ATC iPort - SETP

Target Information: Target is set internally; in accordance to Quality Improvement Plan (QIP) metric

Benchmark Information: Based on iPort SETP Medium Community Ontario hospitals quarterly performance

	2015/2016				2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Surgical Checklist Rate (%)	98.9%	99.2%	99.5%	99.5%	98.4%	99.0%	99.7%	
Benchmark (%)	99.6%	99.6%	99.7%	99.7%	99.7%	99.8%	99.7%	
Target (%)	100.0%	100.0%	100.0%	100.0%	99.6%	99.6%	99.6%	99.6%
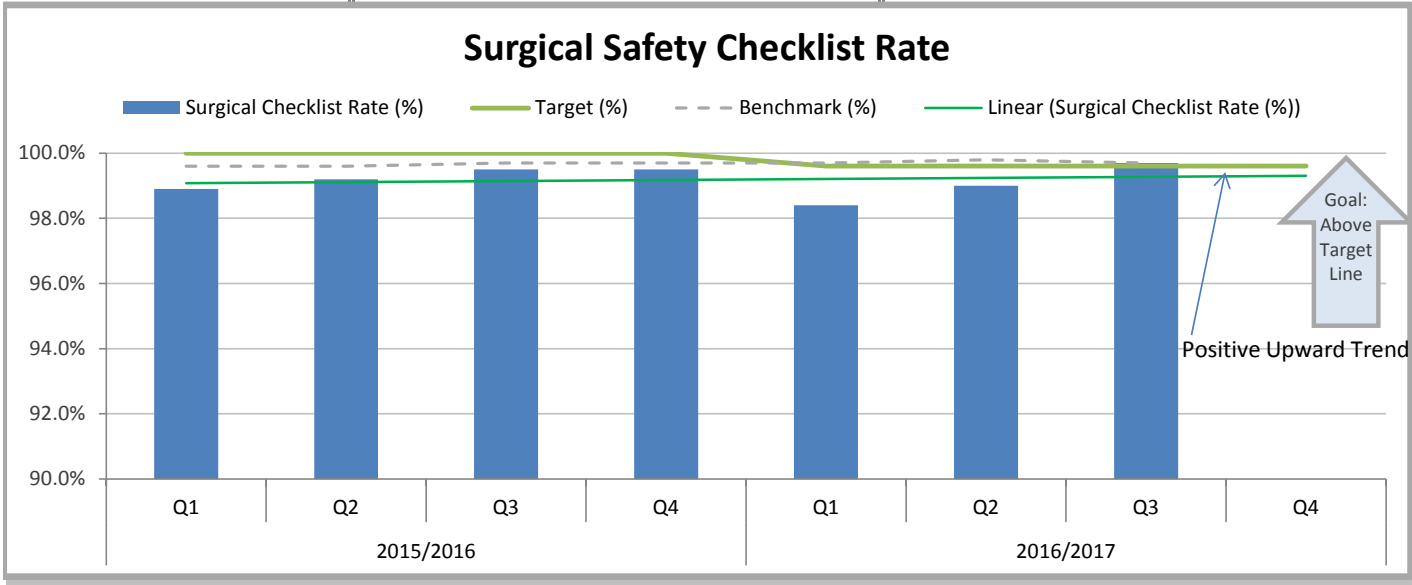
Performance Analysis:

Q1 Slightly below target.

Q2 Improved from Q1.

Q3 Q3 is at the highest rate since Q3 2013-2014.

Q4

Plans for Improvement:

Q1 None at this time. Will be easier to track and document once the electronic health record is implemented.

Q2 This checklist will be a mandatory field in Cerner, and will be automatically transferred to the source of data for this indicator. This will improve data accuracy and simplify the follow up process.

Q3 Continue with current processes.

Q4

Accountable: Senior Director Emergency and Operating Room / Medical Director Operating Room

Indicator: Clostridium Difficile Incidence

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

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

Target Information: Target rate is set according to HSAA specifications

Benchmark Information: Benchmark rates taken from provincial surveillance

	2015/2016				2016/2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
C. Difficile (rate)	0.46	0.51	0.15	0.07	0.53	1.09	0.57	
Benchmark (rate)	0.26	0.26	0.26	0.25	0.22	0.19	0.24	
Target (rate)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
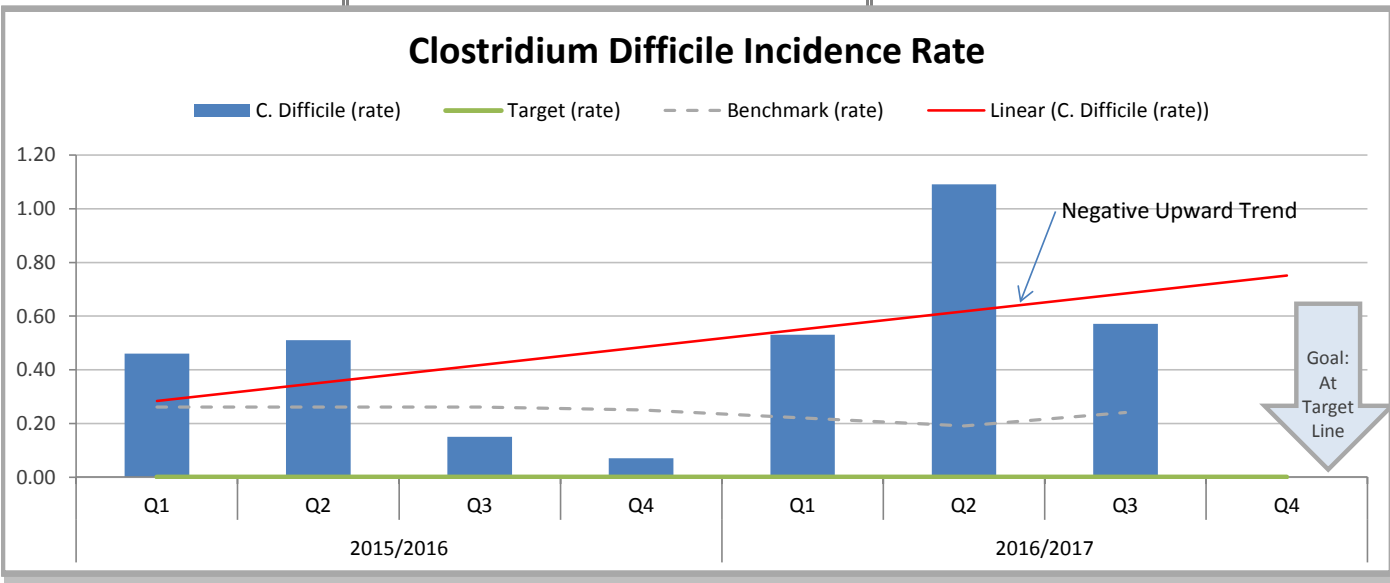
Performance Analysis:

Q1 This represents 6 cases which were not epidemiologically linked, so transmission was prevented.

Q2 This represents 8 cases which were not epidemiologically linked, so further transmission was prevented.

Q3 This represents 8 cases which were not epidemiologically linked, so further transmission was prevented. The rate differs from Q2, which reported the same volume, because our patient days (denominator) were significantly higher in Q3.

Q4

Plans for Improvement:

Q1 Enhanced environmental cleaning with sporicidal and high touch areas was put into place on Medicine JMP1. We will continue to reinforce hand hygiene and early detection practices.

Q2 Continued emphasis on use of cleaning checklists following PIDAC Best practices, where all high touch items must be identified as being cleaned. Continue to re-inforce hand hygiene and early detection practices and antimicrobial stewardship. Increased cleaning requirements warrant a review of resources and staff scheduling.

Q3 Continue with Q2 recommendations. Bi-weekly vs monthly monitoring of cleaning disinfectants is required.

Q4

Accountable: VP Operations / Infection Prevention and Control

Indicator: Ventilator-Associated Pneumonia Incidence Rate

Strategic Direction: Partnering for Patient Safety and Quality Outcomes

Definition: Intensive Care (ICU) Ventilator-Associated Pneumonia (VAP) cases per 1000 device days.

Significance: One Component of the Safer Healthcare Now (SHN) reporting initiative and is required by the Ministry of Health and Long Term Care (MOHLTC).

Data Source: Infection Prevention & Control

Target Information: Target rate is set according to HSAA specifications

Benchmark Information: Benchmark rates taken from provincial surveillance

	2015/2016				2016/2017			
	Q1	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**
VAP Incidence (rate)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	
Benchmark (rate)	0.92	1.09	0.72	0.83	0.51	0.87	0.58	
Target (rate)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
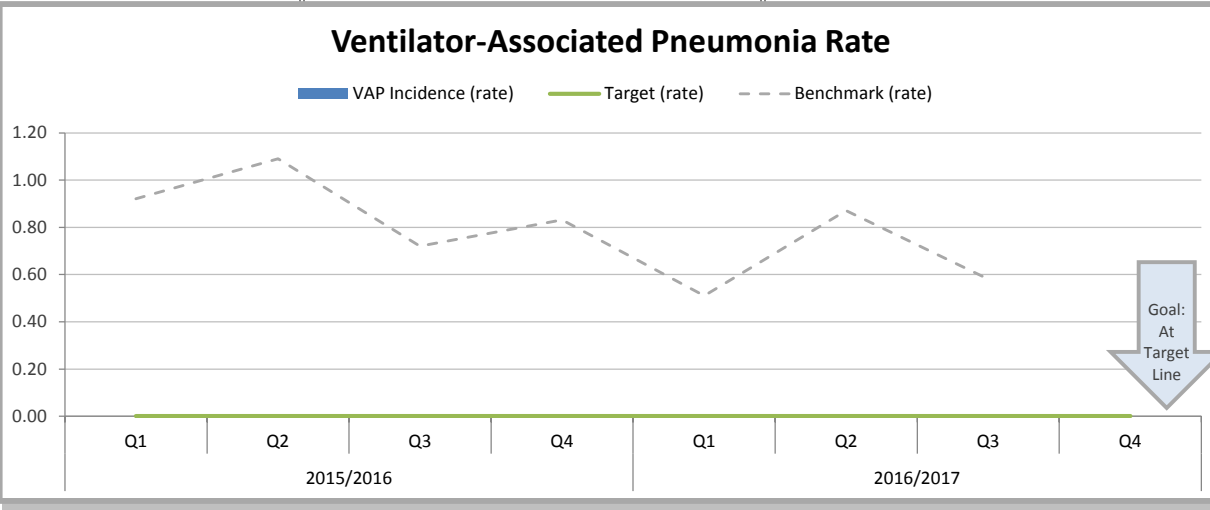
Performance Analysis:

Q1 Target met.

Q2 Target met.

Q3 Target met.

Q4

Plans for Improvement:

Q1 Continue to follow best practices for ventilation maintenance.

Q2 Continue to follow best practices for ventilation maintenance.

Q3 Continue to follow best practices for ventilation maintenance.

Q4

Accountable: VP Operations / Infection Prevention and Control / Director Critical Care

Return to Dashboard