Let's Make Healthy Change Happen.

Quality Improvement Plan (QIP) Narrative for Health Care Organizations in Ontario

Cornwall Community Hospital
Hôpital communautaire de Cornwall

2024-03-07

This document is intended to provide health care organizations in Ontario with guidance as to how they can develop a Quality Improvement Plan. While much effort and care has gone into preparing this document, this document should not be relied on as legal advice and organizations should consult with their legal, governance and other relevant advisors as appropriate in preparing their quality improvement plans. Furthermore, organizations are free to design their own public quality improvement plans using alternative formats and contents, provided that they submit a version of their quality improvement plan to Health Quality Ontario (if required) in the format described herein.

Overview

This year CCH proudly celebrates 20 years of Integrated Care where we have remained steadfast in our journey of growth, integration, and innovation to meet the growing needs of our communities in Cornwall, the SDG Counties, and Akwesasne. Guided by our mission, Our Team collaborates to provide exceptional people-centered care, maintaining a culture of quality and safety remain our top priorities.

CCH's Quality Improvement Plan (QIP) for 2024/25 continues to align with our vision "Exceptional Care. Always." by supporting timely and safe access to care for all those within our community. Over the past year, CCH has maintained a focus on quality, patient safety, and patient and caregiver experience.

As in past years, our QIP is developed in collaboration with key stakeholders including our Patient and Family Advisory Committee. It is further informed by feedback from our patients and families, staff, and best practices including Accreditation Canada Standards' Required Organizational Practices.

Looking forward to the 2024/25 QIP, CCH is focused on priority issues including Access and Flow, Equity, Experience, and Safety. The following QIP indicators will be our focus in the coming year:

1. Wait time to physician initial assessment (PIA)
2. Percentage of staff (executive-level and management) who have completed relevant equity, diversity, inclusion, and anti-racism education
3. Percentage of respondents who responded "completely" to the following question: 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?
4. Medication Scanning Compliance

CCH will continue to make quality improvements a priority. As change ideas are implemented, the performance indicators are monitored closely.

Access and Flow

Timely access to hospital services is a focus for CCH as noted in our Strategic Priority, Enhancing access to care. We endeavor to ensure that our patients receive quality safe care in the right place, at the right time. To impact systemic changes to improve access and flow, we focus on transitions of care by ensuring timely, meaningful discharge planning, preventative admission and readmission initiatives, and a focus on Emergency Department wait times. This concentrated attention on access and flow will help us deliver high-quality care and improve patient and family satisfaction with better health outcomes.

Equity and Indigenous Health

Building on the Strategic Priority of Building a Culture of Equity, Diversity, and Inclusion (EDI) and Embracing Reconciliation, CCH has successfully onboarded 2 new positions, a dedicated Indigenous Patient Navigator and an Equity, Diversity, and Inclusion Coordinator, that will help us better meet the needs of our diverse community. In addition to the new positions, CCH formed an internal EDI Committee and completed our first internal EDI survey to attain a baseline understanding of the

identities and thoughts of our team related to EDI. This will provide an understanding of the needs and gaps related to EDI at CCH to guide our path forward.

The multidisciplinary Committee is working to increase awareness across CCH through initiatives such as monthly notable date recognition, delivery of numerous equity, diversity, and inclusion and Indigenous health-related training, and resources to staff, physicians, midwives, and volunteers. In addition, the Committee reviews policies, procedures, and practices from an equity diversity and inclusion-related lens.

This year's QIP highlights this initiative in the EDI training indicator where we commit to increasing cultural awareness and increase safety through EDI education and training amongst our executive level and management team. CCH has made a long-term commitment to fostering an environment where every person feels safe and valued.

Patient/client/resident experience

At CCH we recognize that a positive patient/client experience directly impacts safety outcomes. When patients receive people-centered care that is culturally safe and respects their preferences, needs, and values, their overall health improves.

We acknowledge that measuring the patients' experience is integral to driving improvements in our practices and enhancing the quality of care we deliver. At CCH, we send out standardized Ontario Hospital Association-approved surveys to patients who have received care within our in-patient units and Emergency Department. The information gathered from the surveys offers insight into the patient's experience and perspective. We use this information to strive for continuous improvement and consider this feedback essential to our work.

The patient/client experience is greatly impacted by how we at CCH, partner with patients, families, and caregivers. We are proud to have launched the Essential Caregiver Program this past year, a compassionate and forward-thinking initiative that will help redefine people-centered care and family engagement at CCH. The program identifies, includes, and supports the caregiver to acknowledge their vital role in the healthcare journey and works to actively include them as partners in the care process.

Provider experience

CCH staff, physicians, midwives, and volunteers, like other healthcare professionals across Canada, have experienced unprecedented impacts due to Health Human Resource (HHR) pressures. CCH demonstrates our commitment to our Strategic Priority of Supporting the well-being of our people to improve the provider experience.

CCH launched our Talent Management Plan in 2023 to ensure the coordination of an effective talent management strategy throughout the organization in alignment with our strategic priorities. This comprehensive plan will work to ensure the ongoing success of CCH in our recruitment and retention efforts.

In addition, CCH has a dedicated Hospital Wellness Committee with a mission to promote a healthy workplace culture that supports employees to achieve optimal well-being and enhance their work-life

experience. The objectives include developing, designing, and implementing wellness activities and initiatives that will support employee wellness and work-life balance. Initiatives such as dedicated staff extracurricular events, Staff ICARE awards, and Years of Service Award dinners demonstrate this commitment.

Safety

Through partnering with patients, caregivers, staff, physicians, midwives, and volunteers, we work to mitigate patient safety risks and respond to patient safety events. An Incident Management Toolkit was developed and launched for all members of the management team to serve as a guide for leaders to manage safety incidents. This resource focuses on the actions to take when a patient safety incident occurs with practical strategies and resources. Also included are methods for sharing learning broadly throughout the organization and with patients and families.

In efforts to enhance the culture of safety and proactively identify and implement risk reduction strategies, CCH implemented a "Good Catch" award. This monthly award recognizes an employee, physician, or volunteer who reports an event or circumstance that had the potential to cause an incident but did not occur due to corrective action or timely intervention. This initiative endeavors to build an environment that fosters safety reporting with the intent to prevent system breakdowns before they occur, ultimately reducing the overall number of incidents and adverse events.

To further support safety, CCH has introduced a new Quality, Patient Safety, Patient Experience, and Risk Management Specialist role. With accountability to collaborate and provide clinical review, root cause analysis, and consultation on patient safety incidents, the Specialist will support the development, implementation, and dissemination of recommendations from the reviews. A primary focus is to support patient and family engagement in patient safety improvement activities and to seek feedback regularly.

Population Health Approach

CCH is working in partnership with the Great River Ontario Health Team on population health-based approaches to care for the unique needs of our community. This collaboration focuses on building partnerships within our communities with all those providing health and social services. A co-design model that includes a Lived Experience Partner Table, French Language Service Table, Indigenous Community Table, and more, supports inclusive system transformation. CCH is proud to partner with the Great River OHT, as one coordinated team, to provide integrated services and support.

Executive Compensation

Cornwall Community Hospital performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role is 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 Officer/Chief Operating Officer
- Chief of Staff

Contact Information/Designated Lead

Kelly Shaw
Interim Vice President, Patient Services, and Chief Nursing Officer
Kelly.shaw@cornwallhospital.ca

Sign-off

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan

Josée Payette
Chair
Board of Directors

Kristen MacDonell
Chair
Quality and Performance Monitoring Committee

Jeanette Despatie
Chief Executive Officer

Kelly Shaw
Interim Vice-President, Patient Services, and
Chief Nursing Officer

2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

Cornwall Community Hospital, 840 McConnell Avenue, Cornwall , ON, K6H 5S5

2024-03-07

M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)

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
Access and Flow	**Timely**	Emergency Visits - Wait Time for Physician Initial Assessment (PIA)	C	90th percentile / ED patients	CIHI NACRS / April 1st 2023 to September 30th 2023 (Q1) and (Q2)	967*	5.9	5.00	CCH FY22-23 final ranking results were 56 with a wait time 90th percentile of 5.7. Obtain 10% ranking score improvement with a 90th percentile wait time of 5.0 or less.		1)Provide timely patient access to ED physician and/or physician assistant after triage.	Timely assignment to ED physicians and/or physician assistants (Optimize PA utilization in ED).	90th percentile PIA.	That by end of Q4 obtain 10% improvement in order to rank 5 points higher than benchmark for Pay for Results Funding (P4R) initiative	
Equity	**Equitable**	Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	967*	CB	85.00	New indicator. Incremental target to obtain 85% by year-end.		1)Develop and launch Learning Management System (LMS)module with CCH customized EDI anti-racism training.	Collaborate with Clinical Informatics/LMS Lead and EDI Coordinator to develop and digitize.	Create SCORM LMS module.	That by end of Q1, module will be developed, launched accessible to target management group.	
											2)Communicate to target management team the mandatory training.	Communicate via management huddles, memo and LMS automated reminder emails.	Present at Q1 management huddle; send out memo with mandatory training requirement to target audience; auto generated emails to target audience via LMS upon training module launch and routine reminders as per LMS reminder schedule.	That by end of Q1, all communication complete.	
											3)Monitor performance quarterly.	Review LMS training completion report.	Review data provided by LMS report.	That by Q1 reach 25% training completion; Q2 reach 50%; Q3 reach 75%; and reach 85% of target group trained.	
Experience	**Patient-centred**	Percentage of respondents who responded "completely" to the following question: 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	967*	60	70.00	New indicator to establish baseline. Target for FY24-25 set using average peer benchmark hospital results for FY20-21.		1)Audit the use of Patient Oriented Discharge Summary (PODS) through the electronic health record.	Audit the use of PODS through the electronic health record.	Number of patients receiving a POD on discharge/number of discharges.	By July 2024 75% of patients on the Medicine unit will receive PODS information on discharge. By July, 2024 75% of discharges (home) from CCU have received a PODs. By July 1, 2024 75% of admitted patients discharged from ED have received a PODs.	
											2)Continue to educate staff and physicians about Healthwise.	Audit the use of HealthWise educational material given to patients.	Number of patients receiving educational material from Healthwise/total number of discharges.	By July 1, 2024, 40% of patients on Medicine unit will have received Healthwise information.	

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) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
											3)Support the process of the Patient Discharge folder to assist patient retaining the educational material provided during their course of stay. The folder includes a letter from our CEO related to the potential to receive a survey after they leave the hospital asking about the information they received to assist in caring for themselves at home.	Audit the number of admitted patients receiving the new created "Discharge folder" - to be distributed by a volunteer on Day 1 of admission.	Number of patients receiving a discharge folder/total number of admissions.	By the end of Q1 total number of admitted patients receiving a Discharge folder 50%, Q3 75%.	
Safety	**Safe**	Medication Scanning Compliance. Measures percentage of medications administered (scan or override selected) for which a medication scan was completed for all inpatient and ED patients.	C	% / All Inpatients and ED patients	In house data collection / Most recent 9 month period	967*	73.4	85.70	Baseline target established through data from FY2022/23.		1)Monthly review of medication administration related audits with staff .	Review audits on medication scanning compliance and medication scanning override reasons and huddle with staff monthly.	Documentation of monthly huddles completed.	Ongoing. By Q1, managers to review monthly audits on medication	
											2)Complete education on the importance of barcode medication administration (BCMA) processes with staff administering medications to patients.	a) Complete organization-wide education blitz with staff on the correlation between BCMA and decreased medication incidents through various methods (huddles, posters, emails).	Complete 1 month education blitz.	By end of Q1, complete 1-month education blitz.	
											3)Complete education on the importance of barcode medication administration (BCMA) processes with staff administering medications to patients.	b) Modify medication administration practice scenarios utilized in initial EHR onboarding.	Completed updated practice scenarios for EHR onboarding.	By end of Q2, update practice scenarios for EHR onboarding.	
											4)Performance Recognition.	Introduce an organization wide BCMA Performance Recognition program.	a) Evaluate methods of performance recognition with departmental councils.	Development of BCMA Performance Recognition program by end of Q1.	
											5)Performance Recognition.	Introduce an organization wide BCMA Performance Recognition program.	b) Establish an organization wide method of performance recognition.	Communication and introduction of BCMA Performance Recognition program by end of Q2.	
											6)Patient Engagement.	a) Complete environmental scan of barcode medication administration (BCMA) strategies used by other hospitals in Ontario.	Completion of discussions with 3 other sites with an active BCMA patient engagement strategy.	Complete environmental scan and presentation to PFAC by end of Q2.	
											7)Patient Engagement.	b) Present findings of the environmental scan and CCH BCMA current rates with the Patient and Family Advisory Committee (PFAC).	Complete presentation with PFAC.	Development of strategy for patient-facing education on the importance of BCMA by end of Q3.	
											8)Patient Engagement.	c) Establish a strategy for patient-facing education on the importance of BCMA.	PFAC endorsed patient-facing education strategy on the importance of BCMA established.	Implement a strategy for patient-facing education on the importance of BCMA by end of Q4.	
											9)Leverage Technology	Implement handheld mobile technology with BCMA capabilities.	a) Completion of current state analysis of medication administration processes.	Complete current state analysis by end of Q1.	

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) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)															
											10)Leverage Technology.	Implement handheld mobile technology with BCMA capabilities.	b) Completion of future state analysis of medication administration processes.	Complete future state analysis by end of Q2.	
											11)Leverage Technology.	Implement handheld mobile technology with BCMA capabilities.	c) Completion of education on integration of handheld mobile technology with BCMA workflows.	Education completed and handheld mobile solution integrated into medication administration workflows by end of Q3.	