Ontario Health

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

Date 2022/23

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 the relationships that care. We are immensely proud of our people for their strong presence; their commitment to teamwork ensuring our patients continue to receive *Exceptional Care. Always*

Our team is comprised of 1,269 employees that include 512 registered nurses & registered practical nurses, 185 credentialed physicians along with an extra 187 volunteers in addition to the employee number. Over the last year, CCH has seen exceptional care by the numbers including 52,237 emergency visits, 98,125 diagnostic imaging tests, 64,600 community addiction & mental health visits, 1,706 chemotherapy treatments, 8,463 dialysis treatments, 4, 906 surgeries performed and 527 births.

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 community that is served by Cornwall Community Hospital has a population of approximately 110,000 and includes the Akwesasne First Nations Community. Cornwall is among the 20% most deprived areas in Ontario; 47% of the population has post-secondary education and 14.5% are living below the low-income cut-off. Within the Champlain Local Health Integration Network, the Cornwall area is noted to have the highest rate of Chronic Obstructive Pulmonary Disease (COPD), the second highest stroke rate and a very high diabetes rate especially amongst the Indigenous population. Cornwall's population has a higher percentage of seniors residing in the area; 23.2% of the population is 65 years and older compared to the province at 16.7%. According to the 2016 Statistics Canada report, 41.7% of the residents of Cornwall speak both English and French.

Despite the unprecedented challenges of this global Pandemic felt across the healthcare industry, our teams continued to work exceptionally hard, making changes to services and continuing to meet the needs of our community moving the hospital forward. We have worked to find a balance in managing the priorities of Pandemic activity, recovery & support for staff within the organization and continuing with our quality improvement activities.

The 2022/23 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.

In order to support the 2022/23 Quality Improvement Plan, Cornwall Community Hospital will strive to further improve the capacity of the organization's quality agenda by focusing on the indicators below. These are priority (P) or mandatory (M) indicators as defined by Health Quality Ontario.

1. Number of inpatients receiving care in unconventional spaces (P)
2. Time to inpatient bed (M)
3. Discharge summaries sent from the hospital to primary care provider within 48 hours of discharge (P)
4. Number of violence incidents (M)
5. Medication reconciliation at discharge (P)
6. Repeat emergency visits for mental health (P)

CCH will continue to improve our performance with the indicators as outlined in our workplan.

REFLECTIONS FROM 21/22

There are many initiatives to be proud of and the following highlights a few.

Radioactive seeds are now helping surgeons pinpoint breast cancer tumors at CCH.

Last year, CCH became one of the few hospitals in Canada to offer a procedure called breast seed localization (BSL), a more comfortable and efficient alternative to wire localization, to pinpoint and remove nonpalpable tumours. Inspired by her own mother's journey with breast cancer, Dr. Sahar Shirazi is a general surgeon at CCH who achieved her fellowship in breast surgical oncology and oncoplasty from the University of Ottawa's school of Medicine. Dr. Shirazi introduced the idea of using radioactive seeds here at CCH following her positive experiences using BSL for at the Ottawa Hospital.

CCH Becomes First Hospital in Canada to Integrate SeamlessMD with its Electronic Health Record.

In March 2022, CCH launched SeamlessMD, a Digital Engagement platform used by hospitals and health systems across North America to improve the surgical patient experience. SeamlessMD has bee implemented across surgical service lines including Total Hip and Knee Replacement, Shoulder, Breast, Colorectal, and for certain emergency general surgeries. After surgery while recovering at home, patients can now access education and self-report data such as pain scores, symptoms range-of-motion, and share photos of their wounds through the platform remotely. With this platform, patients are empowered to take charge of their own care, as it provides the tools to effectively self-manage at home.

Echocardiography Services at CCH Receive Nationally Recognized Accreditation

In 2021, CCH's echocardiography services received full accreditation through Accreditation Canada Diagnostics Echocardiography Quality improvement program for providing high-quality echocardiography services and meeting nationally recognized standards. This means our services meet the highest standards of care in the country, and demonstrates to our community, patients and staff that our hospital places an emphasis on continuous learning and ongoing improvements. The rigorous process involved physician panels assembled by Accreditation Canada who reviewed patient cases, hospital equipment, the team's training and skills, and examined the programs processes. CCH successfully implemented all quality improvement suggestions to receive the full accreditation and become an accredited echocardiography facility.

Hospital Awarded by Ontario Health for Championing Organ and Tissue Donation

CCH was recognized by Ontario Health (Trillium Gift of Life Network) in 2021 with the Eligible Approach Rate Award for its outstanding efforts to integrate organ and tissue donation into quality end of life care.

This award is presented for exceeding the eligible approach rate target of 90% set by Ontario Health. It recognized CCH for demonstrating leading practices by facilitating donation discussions with eligible patients/families of patients at end of life. Early in 2022, CCH paid tribute to organ and tissue donors and their families with a new memorial display in the waiting room of the hospital's critical care unit.

The launch of the CCH new District Stroke Unit

On June 20th 2022, the City of Cornwall Councillor Syd Gardiner and members from the Champlain Regional Stroke Network were at Cornwall Community Hospital (to cut a ribbon alongside CCH Board Chair Josée Payette and President & Chief Executive Officer Jeanette Despatie celebrating the opening of a new Acute Stroke Unit.

The new Acute Stroke Unit houses 10 designated beds for patients with a stroke diagnosis requiring hospital admission.

The unit is staffed by a specially-trained multidisciplinary team of doctors, nurses, therapists, and others, who will work with stroke patients and their families to determine the next steps for recovery.

As a District Stroke Centre within the Champlain Regional Stroke Network, CCH is the hub for patients in Eastern Champlain who need stroke care. This includes being the only local hospital capable of: administering clot-busting medication; conducting emergency tele-stroke consults with a neurologist; operating an outpatient stroke prevention clinic; and now, caring for stroke patients and helping them recover in a dedicated Acute Stroke Unit. "Local residents can take comfort in knowing they are receiving these high-quality healthcare services at Cornwall Community Hospital, who continue to work hard to enhance the care offerings and services in our community," said Councillor Gardiner.

Ontario Health Team Announced for Upper Canada, Cornwall and Area

In 2021, the Government of Ontario in partnership with Ontario Health announced that Ontario Health Teams (OHT) would be formed across the province, including one covering the United Counties of Stormont, Dundas and Glengarry, City of Cornwall, Akwesasne, parts of Russell Township and rural south-east Ottawa.

The Upper Canada, Cornwall and Area OHT is made up of more than 30 regional healthcare providers, including CCH, and will eventually transform the way care will be delivered across Eastern Ontario for the benefit of local patients.

OHTs provide better integrated care by breaking down barriers that may exist between healthcare providers and geographic areas. They combine various health services, including physicians and nurse practitioners, hospitals, home and community care, community support services, mental health and addictions services, community health centres, and long-term care.

The vision at maturity, is that local people will experience easier transitions from one provider to another, including, between hospitals, home care providers or long-term care homes, with one patient story, one patient record and one care plan.

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.

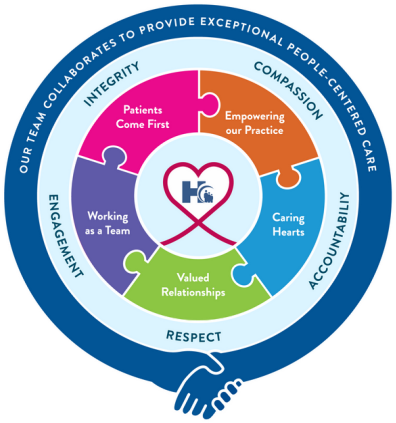

Figure 1.0

- **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 approach.
- **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.

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 Human Resources Officer
- Chief of Staff

Contact Information

Linda Gravel
Vice President Patient Services and Chief Nursing Officer
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SIGN-OFF

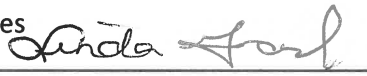
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on September 21, 2022

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: 

2022/23 Quality Improvement Plan
"Improvement Targets and Initiatives"

Cornwall Community Hospital
Hôpital communautaire de Cornwall

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) C = custom (add any other indicators you are working on)															
Theme I: Timely and Efficient Transitions	**Patient Centered** **Efficient** **Safety**	**Inpatients Receiving Care in Unconventional Spaces per Day.** 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).	P	Count / All inpatients	Daily BCS / TBD	967*	0.2	1.00	Baseline target and performance achieved for FY1920. Keep same target as prior year at a daily average of one within period.		1)Continue to work with the Chiefs and medical teams to align Length of Stay (LOS) with Expected Length of Stay (ELOS) targets established from our HIG peer group.	Provide Chiefs and Department Managers Length of Stay (LOS) reports.	Length of Stay = Expected Length of Stay (ELOS) unless variance supported by documentation.	Overall Total = 105.0% (Corporate Scorecard) Medicine = 117.0% Surgery = 92% Ortho = 82% Hospitalist = 115.0%	Length of Stay (LOS) that exceed target should be tracked when gaps in the system. (In order to protect patient privacy "X" is used when there are any indicators with numerator less than 5 and denominator less than 30
											2)Organizational project working with Hospitalist program in collaboration with all clinical programs to improve over all flow in hospital - admission to discharge	Data to be tracked and reported to the Length of Stay Working Group by Decision Support team	Track Daily Access Reporting Tool (DART)	That on average, 100% of patients will be admitted to a conventional bed.	
											3)Encourage chiefs to transfer patients to rural hospitals that have capacity.	Number of patients repatriated from ER to HGMH or WDMH.	Track occupancy of other hospitals utilizing the LHIN Daily Flow Report.	That when occupancy is greater than 90%, patients will be transferred to a rural hospital.	
											4)Level out the number of surgical cases over 5-day elective booking period.	Number of cases by day of the week.	Track the number of OR cancellations related to shortage of surgical beds.	0 (zero) cases cancelled.	
	Timely	**Discharge Summary Sent From Hospital to Primary Care Provider Within 48-Hours of Discharge.** This indicator measures the percentage of patients discharged from hospital for which discharge summaries are delivered to their	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	967*	68.48	80.00%	New indicator for FY2021. Collecting baseline. Target set at 80.0%.		1)Improve utilization of structured documentation discharge templates to ensure timely exchange of information to primary care at discharge.	a) Continue to provide "elbow support" to physicians during onboarding to set up personal requests in templates and ensure strong understanding of technology/processes. b) Track the percentage of discharge summaries using structured templates.	a) Number of new providers receiving elbow support/ total number of new providers onboarded. b) Number of patients with a structured discharge note/total number of discharges	ByQ3 2023 80%	
											2)Evaluate the turn-around time for completion of discharge notes	Track the turn-around time from discharge to distribution of the discharge summary to measure the percent received in 48 hrs	Number of discharge summaries "distributed" in 48 hrs/ total number of discharge summaries	By the end of Q3 80%	

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
		primary care provider within 48 hours of patient's discharge from hospital.									3)Assess the quality of documentation received by primary care - are they receiving what they need for continuity of care	Seek feedback from the community primary care providers on the new templates and their usefulness and/or gaps	Analysis of a feedback tool distributed to primary care providers and review of workflows as indicated.	By Jan 2022 greater than 80% satisfaction.	
		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.	**p**	**Hours / All patients**	**CIHI NACRS, CCO / Oct 2019– Dec 2019**	**967***	**21.35**	**23.9**	**Target established at 7% reduction of FY1920 target of 22.6.**		**1)Early discharge planning is embraced as part of organizational culture and philosophy of care.**	**Continue with the corporate project of monitoring Time to Inpatient Bed (TIB) with a goal of meeting or exceeding target.**	**Track the metrics for Time to Inpatient bed using the Daily Access Reporting Tool (DART).**	**That by Q 3/4 - TIB will be less than or equal to 21.0**	**Target justification is aggressive as performance excellent in q1-3; typically more challenging in q4 (*Formula is 23.8 * (1 - 5%) =22.6)**
											2)Organizational project working with Hospitalist program in collaboration with all clinical programs to improve over all flow in hospital - admission to discharge	Hospitalist working group to monitor volume of patients per physician.	Track the number of patients per hospitalist related to number of discharges	By end Q4, 2020, hospitalist case load not to exceed 27 patients (Monday - Friday)	
											3)Realign hospital services to ER activity.	Daily review of DART - TIB.	Track the number of times that target for TIB is not met.	By the end of Q2, TIB less than or equal to 21.0	
Theme III: Safe and Effective Care	**Effective Safety**	**ROP - Medication Reconciliation on Discharge Rate.** 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).	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	967*	86.4	85%	Continue to maintain or exceed last FY1920 performance. Continue with same target of 85% as prior fiscal year.		1)Optimize information shared with community partners obtained via medication reconciliation at discharge to promote patient safety.	Track the number of fax referrals that were made from CCH to community pharmacies and primary care practitioners.	Number of (e-referrals or faxes) made to primary care practitioners.	85% of patients will have medication reconciliation completed on discharge by July 2020.	
											2)Leverage technology to improve medication information from hospital to primary care practitioners at the time of patient discharge.	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 at discharge. 90% of CCU patients discharged home from the unit will have med reconciliation completed at discharge.	
											3)Promote awareness of polypharmacy when preparing discharge prescriptions (Senior Friendly Initiative) at Medical Grand Rounds.	Track number of patients discharged that are greater than or equal to 65 year of age that have medication reconciliation	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 seniors will have medication reconciliation completed on 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
		Repeat ED Mental Health Visits MSAA & HSAA The percentage of repeat emergency visits (for a mental health condition) following an emergency visit for a mental health condition. The repeat visit must be within 30 days of the 'index' visit (first visit). This is based on the Most Responsible Diagnosis (mental health codes - ICD-10) and includes only CCH cases	P	% / ED patients	CIHI NACRS / April - June 2019	967*	17.78	16.30%	Target established through HSAA agreement. Current performance of 17.78% for Apr-June.2019 is auto-populated by QIP-HQO using return visits from all other facilities. CCH results for Apr-June.2019 using only return visits to CCH shows current performance of 13.3% for Apr-June.2019.		1)Initiate process that facilitates coordinated care for Repeat ED patients	Generate a real-time report through our electronic health record for repeat ED patients.	A health link Coordinated Care Plan developed for repeat ED patients	70% of repeat ED patients have a coordinated care plan	
											2) Ensure complex clients (who have police involvement and mtal illness/addition issues) are referred to Safe bed Program as required	Work with ED staff/physicians/ inpatient Community-based Mental Health Services to increas awareness of and referrals to Safe Bed Program		Safe Beds Program has an occupancy of 80% or greater	
											3) Increase number of clients served vy brief services models through both the Crisis and Adult MH Services	Grow the aviabliety of Brief services	Increase the rate of patients seen less for 3 or fewer sessions.	A 10% increase in the number of adults served through adult mental health services	
	Safe	**Workplace Violence Prevention - Incidents. The number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12-month period. Awareness created in 22/23; the goal for last quarter 2023/24 will be to have less incidents.**	P	Count / Worker	Local data collection / Jan - Dec 2019	967*	223	75% increased	Create a culture of reporting and an increase will be seen in reporting		1)Continue on and report on progress made utilizing the various tool kits to promote safety; risk assessments, individual chart risk assessment, flagging security and personal safety response systems. Optimize information that has transferred from police to ER department Health IM (policy software purchased by police) to establish safety plans for staff.	Tracking through the JHSC Vilolence Sub Committee in collaboation with the Police Liaison Committee the number of patients brought to ER by Cornwall Police Services wherein Health IM has been utilized.	The number of times a patient in ER is restrained (as reported through the electronic incident reporting system).	To decrease the number of reported incidents of violence in year 2	
											2)Support staff to navigate the judicial system when charges are laid against a patient or external perpetrator.	Number of incidents that result in personal injury or damage to hospital property.	Track number of assaults or threats that result in charges being laid.	Track through the JHSC Sub Violent Sub Committee in collaboration with the Police Liaison Committee.	
											3)Continue to evaluate the efficacy of training programs delivered by the hospital.	Obtain feedback from staff through our work life pulse survey and during quality reviews and ad hoc surveys	Track compliance of mandatory Nonviolent Crisis Intervention Awareness (NVCI)Training through the Learning Management System (LMS).	80% of all staff will be trained in NVCI Awareness.	
											4) Create culture of reporting	create awareness throughout organization of reporting though monthly reports provided by OHS, looking at continous improvement (user friendly) reporting tools	Track incident reports and look for increase of 67 to 75	Q4 to reach target to 75	
											4)Begin adoption of voluntary standard CSA Z1003, Psychological Health and Safety in the workplace.	Voluntary standard CSA Z1003 Psychological Health and Safety in the Workplace audit tool.	Completion of voluntary standard CSA Z1003, Psychological Health and Safety in the Workplace audit tool to identify gaps.	By Q4 audit tool will be completed with recommendations.	