Let's Make Healthy Change Happen.



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

St. Joseph's Continuing Care - CCC



23 March 2016

### Overview

The focus of our plan is in the dimensions of effectiveness, equity, patient safety and patient experience.

The priority focus in the dimension of patient safety will be the continued implementation of medication reconciliation at time of discharge for all patients being discharged to the community. We are seeing an increase in the number of transitional and restorative care patients; resulting in an increase in the number of discharges.

Our patient-centred objective is to maintain our high level of overall patient satisfaction.

In the equitable dimension our focus will be on increasing the percentage of patients who always receive service in the official language of their choice.

We have identified 2 areas of focus in the effectiveness dimension; namely to increase the percentage of patients in special rehab and to decrease the percentage of patients experiencing pain.

### OI Achievements From the Past Year

For fiscal 2015-2016 we identified the following three aims:

- 1) Safety dimension: To increase the proportion of patients receiving medication reconciliation upon discharge. This was s new practice implemented in the hospital and the target was to achieve 50% in by March 31, 2016 and we achieved 66% by March 15, 2016.
- 2) The second aim in the safety dimension was to reduce hospital acquired infection through hand hygiene compliance before patient contact. Our target for 2015-2016 was to achieve a target of 75% by March 31, 2016 and we achieved 75% by March 23, 2016.
- 3) Patient-Centred dimension: Receiving and utilizing patient experience feedback to improve services measured by the percentage of patients recommending the hospital as determined by in-house survey. Our target for fiscal 2015-2016 was 88% and as of 22 March 2016 we achieved we have achieved 100%.

In addition, St. Joseph's Continuing Care Centre received a Three-Year Accreditation decision awarded to us in May 2015 by CARF International.

### Integration & Continuity of Care

We will continue to provide a blend of service in order to best meet the needs of the system and our catchment area.

The plan to increase resources to effect an increase in the percentage of patients in the RUG Special Rehabilitation grouper is expected to result in better patient outcomes and greater patient flow. The

continued implementation of medication reconciliation at time of discharge for patients returning to the community will help facilitate patient safety through the continuum of care. The hospital remains engaged with health system partners; such as the Cornwall Community Hospital, the Champlain LHIN and the Champlain CCAC to help achieve the provincial priority of patient-centred care across the patient journey.

### **Engagement of Clinicians & Leadership**

The QIP has been informed through the engagement of a multi-disciplinary Leadership Team. The plan has also been presented to the QI Committee of the Board, the Board of Directors and the Professional Advisory Committee, representative membership includes Physicians, NP, RN, Pharmacy and Therapy Services groups.

## Patient/Resident/Client Engagement

The QIP Plan will be presented at Patients' Council to inform and provide opportunity for feedback. In 2016-2017 the Hospital plans to introduce the InterRAI QOL as the assessment tool to determine patient experience and overall quality of service provided. This integrated assessment will allow for more in-depth analysis of patient outcomes as they relate to patient experience.

### Performance Based Compensation

The hospital has only one executive position; namely the Executive Director. The Executive Director is the chief administrator of both the hospital operation and the long-term care operation. For fiscal year 2016-2017 a percentage of annual base salary of the Executive Director as determined by the Board of Directors, will be linked to the achievement of the targets set out in the QIP.

### 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:

Board Chair (signature)

Quality Committee Chair (signature)

Chief Executive Officer Brune Kue ★ (signature)

# 2016/17 Quality Improvement Plan "Improvement Targets and Initiatives"

Hotel Dieu Hospital of Cornwall 14 York Street

| 200 miles 200  | Measure  | STATE OF THE PARTY | 問題が表示と  | でのは、このをはませる |        | STATE OF THE PARTY | Change   | がいる。<br>はいできた。<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたが、<br>はいできたができたができたができたができたができたができたができたができたができたが |  | おいて のまない こと   |
|--|--|--|---|-------------|--------|--|--|--|--|---|
|  |  | Unit/  |   |             |        | Target   | Planned improvement  |  |  | Goal for change   |
|  | Measure/Indicator  | Population   | eriod   |             | à      | justification  | initiatives (Change Ideas)                                       | Methods  | Process measures   | ideas   |
| Increase percentage<br>of patients who<br>received Special<br>Rehab                | Percentage of patients in RUG category Special Rehab as determined through MDS assessment        | % / All patients   | CCRS, CIHI 644* (eReports) / April 2016-March 2017          | 58          | 35.00  | Improvement  | A)Increase patient opportunities to participate in Special Rehab | Ulincrease patient Opetermine appropriate patients through assessments, opportunities to participate provide enhanced PT and OTA/PTA resources to in Special Rehab program delivery  | % patients in RUGs grouper from CIHI CGRS reports  | Quality patient outcomes; achievement of patient activation and rehabilitation goals  |
| Reduce the percentage of patients experiencing pain                                | Percentage of patients experiencing pain as determined through MDS assessment                    | % / All patients   | CCRS, CIHI 644*<br>(eReports) / April 2015-March 2017       | 27.1        | 25.00  | Improvement  | 1)Staff education on pain<br>management and pain<br>assessment   | In-service   | if registered staff receiving in-service / total number of registered staff                                | implement BPG<br>with respect to<br>pain assessment &<br>management; high<br>quality assessment<br>data                                 |
| A CHARLES  | Increase percentage of patients who are always served in the official language of their choice   | % / All patients   | In-house survey / 644*<br>1 April 2016 to<br>March 31, 2017 | 88          | 00.00  | Improvement  | 1)French language testing Utilize third party service for staff  | Utilize third party service  | Defined linguistic abilities as determined by le Reseau  | Increase French<br>language capacity<br>in staff  |
|  | ent  | % / All patients   | In-house survey / 644* I April 2015 - 31 March 2017         | 88          | 00'06  | Improvement  | 1)Hospital will implement<br>InterNAI GoL Assessment             | Identify implementation team, development of implementation plan   | Measure against project charter  | Full implementation during fiscal year, during fiscal year, enhance analyze Clinical and CoL outcomes for any any Eorrelation/trendin 8 |
| Increase proportion of patients receiving medication reconciliation upon discharge | The number of patients discharged to the community for whom a Best Possible Medication Discharge | % / All patients   | Hospital 644* collected data / April 2016-March 2017        | 99          | 100.00 | Improvement  | 1)Continuation of process implementation from 2015-2016 QIP      | Tracking will be done through discharge checklist  | # patients discharged to community with medication discharge plan/total # patients discharged to community | 100% compliance   |