Let's Make Healthy
Change Happen.

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

St. Joseph's Continuing Care CCC

3/5/2015

Overview

The focus of our plan is patient safety and patient experience.

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

A second safety objective is to reduce the rate of hospital acquired infections through hand hygiene.

Our patient-centred objective is to increase the overall level of patient satisfaction.

Integration & Continuity of Care

It is important to note that while our initiatives included the QIP seemingly do not address integration directly the operational plan for the hospital does readily address integration. We will continue to provide a blend of service in order to best meet the needs of the system and our catchment area. The hospital is highly engaged with health system partners; such as the Cornwall Community Hospital, the Champlain LHIN and the Champlain CCAC in the exchange of information and the completion of patient review to facilitate patient-centred care across the patient journey.

Challenges, Risks & Mitigation Strategies

The challenges and risks which may impact on the success of our plan include availability of resources and response to unforeseeable situations. Key assumptions in the plan development is the level of operational funding for the hospital for the planning period 2015-2016 will be equal to that included in our HAPS submission to the LHIN. There is also inherent risk given the small patient population. As with any plan, an unforeseeable event such as outbreak, could negatively impact availability of health human resource and reduce system capacity and create a financial burden for the hospital.

Information Management

The hospital uses the RAI MDS 2.0 as the key clinical information system to capture multi-disciplinary patient assessment information and inform care planning. Assessments are completed on admission, quarterly, annually and when a resident experiences a significant change in health status. The assessment and RAI outputs identify actual and potential care plans and quality indicators. The Home also uses an integrated eMar system.

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.

Patient/Resident/Client Engagement

The QIP Plan will be presented at Residents' Council to inform and provide opportunity for additional feedback. The QIP regarding resident quality of life has been informed by the Resident Survey process; results and feedback from prior period survey presented and discussed at February 2015 meeting.

Accountability Management

The hospital will be accountable to various committees for the successful implementation of the QIP. Most notably, the consolidated results will be reported to the QI Committee of the Board. Other committees, e.g. Pharmacy and Therapeutics, CCC Residents Council, Infection Control Committee and the Professional Advisory Committee will be apprised of the progress for the objectives in their domain.

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 2015-2016 a percentage of annual base salary of the Executive Director apportioned to the Hospital operation and determined by the Board of Directors, will be deemed “at risk” and 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 ________________________ (signature)

2015/16 Quality Improvement Plan for Ontario Hospitals
"Improvement Targets and Initiatives"

Hotel Dieu Hospital of Cornwall 14 York Street

AIM		Measure							Change				
Quality dimension	**Objective**	**Measure/Indicator**	**Unit / Population**	**Source / Period**	**Organization Id**	**Current performance**	**Target**	**Target justification**	**Planned improvement initiatives (Change Ideas)**	Methods	Process measures	Goal for change ideas	Comments
Patient-centred	**Improve patient satisfaction**	In-house survey (if available): provide the % response to a summary question such as the	% / Other	In-house survey / October 2013 - September 2014	644*	85	90	continued improvement	1)Implementation of planned program enhancements as a result of feedback from survey process; e.g. greater access	Tracking process will be done through patient survey.	% patients responding Definitely and Probably to question "I would recommend this facility to others" possible responses: Definitely, Probably, Maybe and No.	88% favourable responses by 31 March 2016	
Safety	**Increase proportion of patients receiving medication reconciliation upon discharge**	Total number of discharged patients for whom a Best Possible Medication Discharge Plan was	% / All patients	Hospital collected data / Most recent quarter available	644*	CB	50	plan to implement new process for medication reconciliation at	1)Development of reconciliation process for medication upon discharge	Tracking will be done through discharge checklist	% of patients who receive a medication reconciliation at time of discharge/ total number of patients discharged	Achieve 50% compliance by 31 March 2016	2015-2016 goal reflects implementation timeline; it is expected that
	Reduce hospital acquired infection rates	CDI rate per 1,000 patient days: Number of patients newly diagnosed with hospital-acquired	Rate per 1,000 patient days / All patients	Publicly Reported, MOH / Jan 1, 2014 - Dec 31, 2014	644*	0	75	Continued process improvement	1)Change ideas include staff re-education on proper hand hygiene; providing more consistent and more frequent audit and	Audit outcomes are included in quarterly balanced scorecard reporting to QI committee and Infection Control committee.	Hand hygiene compliance before patient contact; the number of times that hand hygiene was performed before initial patient contact divided by the number of observed hand hygiene indications for before initial contact multiplied by 100.	To increase compliance to 75%	
		Hand hygiene compliance before patient contact: The number of times that hand hygiene was	% / Health providers in the entire facility	Publicly Reported, MOH / Jan 1, 2014 - Dec, 31, 2014	644*	72	75	Continued improvement	1)Change ideas include staff re-education on proper hand hygiene; providing more consistent and more frequent audit; providing	Audit outcomes are included in quarterly balanced scorecard to QI committee and Infection Control committee.	Hand hygiene compliance before patient contact; the number of times that hand hygiene was performed before initial contact divided by the number of observed hand hygiene indications for before initial contact multiplied by 100	Increase compliance to 75%	