Health Quality Ontario is now part of Ontario Health, a 21st-century government agency responsible for ensuring Ontarians receive high-quality health care services where and when they need them.

Health Quality Ontario's programs and services remain unchanged.

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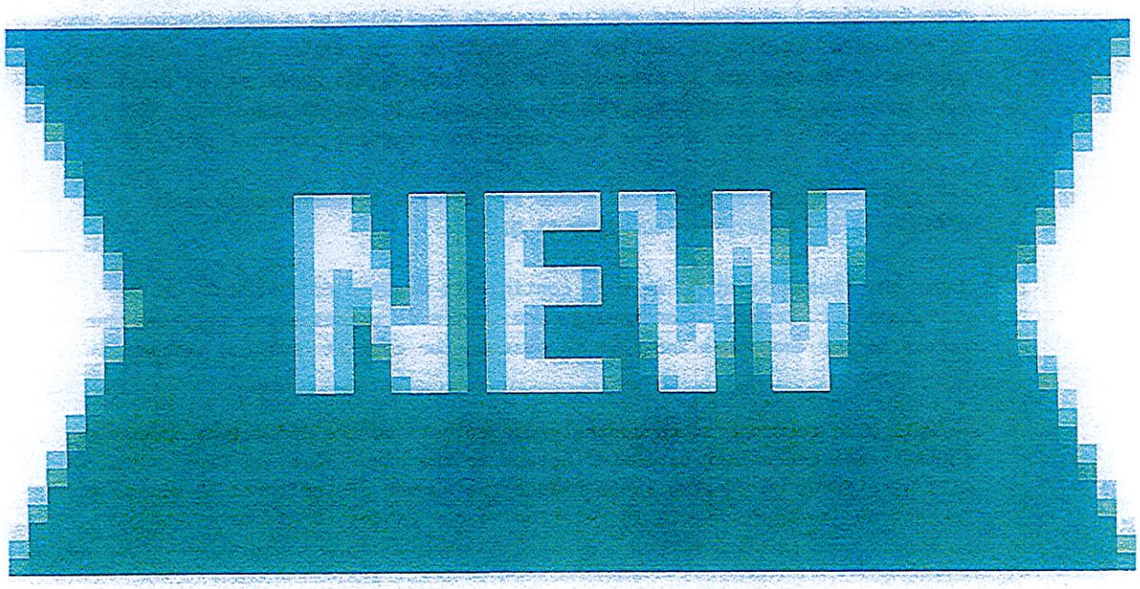
SUBMIT QIP

PROGRESS REPORT | NARRATIVE

2020/21 Quality Improvement Plan

~~Hotel Dieu Hospital - Cornwall~~ Status: SUBMITTED



EXPORT NARRATIVE

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Goto section Overview

Overview

St. Joseph's Continuing Care Centre is a non-profit state of the art institution composed of 150 Long-Term Care beds and also operates a 58 bed complex continuing care program under the name "Hotel Dieu". Our unique centre is located along the shores of the St. Lawrence river in Cornwall, Ontario and is owned and operated by the Religious Hospitallers of St. Joseph's. St. Joseph's Continuing Care Centre is proud to be accredited by CARF International and is also affiliated with Catholic Health International (CHI).

For more than a century the Religious Hospitallers of St. Joseph served in our community and never failed to recognize the needs of the sick, the elderly and the very young. Their legacy of holistic and compassionate care is reflected in our Mission, Vision and Value Statement. We continue to lead by their example and remain committed to improving the life of our seniors and adults affected by loss of autonomy through injury or illness. We continue to serve in the spirit of our founders and remain driven by our mission in working collaboratively within our health system and community partners in provision of services to address community needs.

The services provided by our small hospital include, Slow Paced Rehabilitation (Restorative Care) and Medically Complex Care. Restorative Care is a progressive, dynamic, goal orientated program with the purpose of improving ones functional ability and working towards facilitating a safe discharge home or to another supportive setting. The length of stay varies from 2 weeks to a maximum of 90 days and is dependent on the individuals goals and/or needs. Our slow paced rehabilitation program has successfully transitioned over 350 patients back to their home or retirement home setting over the past year.

This year our organization will focus its efforts in the dimensions of Efficiency and Safety for our 2020-21 QIP.

Under the theme "Safety", we will continue to monitor for violence in the workplace. St. Joseph's Continuing Care Centre is committed to ensuring the safety of our employees and plan to sustain our current level of success in this area.

We will also continue to concentrate our efforts in the Efficiency dimension in the areas concerning patients' access to the right level of care (ALC). We will also focus on strategies to reduce the number of unplanned ED visits and concentrate on improvements in relation to our Estimated Discharge Dates.

Describe your organization's greatest QI achievement from the past year

Our greatest achievement from the past year revolves around our statistics concerning "Expected Date of Discharge" for our patients. Despite the fact that we did not meet our target of 92%, we still managed to successfully discharged 85% of our patients on or before their projected estimated date of discharge. Discharge planning is communicated with patients and families in the beginning stages of their stay, in order to engage and empower patients to set goals and work towards achieving them. Expected discharge dates are written on whiteboards in patients rooms which provides a visual reminder for patients and their families in order to adequately prepare them for their upcoming discharge, and in addition allows them the opportunity to address and resolve any barriers concerning their home environment that may be present. Some of our patients did encounter delays with their discharge which ultimately affected their EDD however these situations were not within their control. Some discharges were postponed due to construction issues at a local community retirement home. Other patients experienced delays to discharge due to the unavailability of services from community providers. Despite these setbacks we were able to safely discharge over 350 patients back home or to other safe, suitable environment within our community.

Collaboration and integration

The interdisciplinary team at our organization works closely with the Cornwall Community Hospital and LHIN Community Home teams. Referrals are forwarded from the hospital for review and consideration for admission into our slow paced rehabilitation programme. We have successfully transitioned more than 350 patients from the Cornwall Community Hospital.

Development of our local Ontario Health Team (OHT) is in the beginning stages. We look forward to working collaboratively with all members of the OHT. The Cornwall and Area Health Team is currently in the Development stages.

Patient/client/resident partnering and relations *

Last year St. Joseph's Continuing Care Centre was provided with the opportunity to conduct a pilot project to create an outreach program for patients to successfully transition back to their home environment, following their discharge from our rehabilitation program. A registered nurse and social worker designed the program, created assessments, followed patients to their home and provided education to other professional organizations. Patients who were assessed and deemed to be at higher risk for readmission back into hospital after their rehabilitation stay were followed by the team upon discharge home. Our social worker and registered nurse worked in collaboration with the local Health Links provider and LHIN Home and Community Case Managers to determine appropriate services for patient's who were being discharged home. The project provided valuable insight in identifying risk factors which contributed to a patient's readmission to hospital following their discharge home, for example, specific medical conditions, de-conditioning from a decrease in activity post discharge, as well as gaps in community services. Unfortunately, the funding for this pilot project ended in March 2019 however, we recognized there is a definite need and benefit with continuing therapy for high risk patients post discharge in order to prevent readmission back to hospital. With this in mind, St. Joseph's Continuing Care Centre has added a part time physiotherapist to our staff compliment to continue with physiotherapy exercises and follow up for our higher risk population in their home environment.

As in the past years, our QIP will be presented to both the Resident and Family Councils for review and discussion.

Workplace Violence Prevention *

Violence in the workplace can have devastating effects on the quality of life for employees and on the productivity of an organization. St. Joseph's Continuing Care Centre is committed to the prevention of workplace violence and ensuring the safety of our employees. A policy was developed defining behaviour that constitutes workplace violence and outlines procedures for reporting and resolving incidents of this type. Our Centre is committed to providing a working environment free of violence by ensuring that all workplace parties are familiar with the definition of workplace violence and their individual responsibilities for prevention and corrective action. Incidents of workplace violence are investigated in a prompt, objective and sensitive way. These incidents are tracked and analyzed by the Joint Health and Safety Committee and Leadership Team to identify trends and to determine prevention initiatives and strategies.
A Code Silver policy was developed over this past year as another means of workplace violence prevention. Code Silver is defined as a planned response to ensure the safety of all healthcare workers, residents, patients and visitors when an individual is in possession of a weapon and an enhanced police response is required. Code Silver was added to our emergency colour code system, staff have been educated on this new code and drills were conducted. Fortunately, our organization did not experience any incidents of workplace violence over the past year.

Virtual care

Our Information Technology Team continues to source new and exciting software programs for our organization which not only keeps us current but also contributes to higher efficiency and production. St. Joseph's Continuing Care has invested in Cliniconex, which is an automated message software program. This system forwards reminders to families of patients via text messaging, phone or email alerting them of upcoming appointments, care conferences and can also be programmed to send out mass announcements regarding outbreak notifications and other important topics that needs to be communicated. This system has effectively reduced the high volume of phone calls front-line staff have had to manually complete in the past, thereby freeing up valuable time and resources, allowing them to focus on patient care at the bedside.

A Secure Conversation feature has also been implemented to our Point Click Care system. This feature enables the medical staff to communicate and collaborate with other members of the health care team through the use of a smartphone. This permits medical staff to discuss patient concerns, forward medication orders and sign off on orders in a timely manner thereby improving patient care and outcomes.

E-Consult is another innovative program which we have utilized for the betterment of our patients. Medical staff have the ability to forward consults and liaison directly with specialists through this software program which reduces wait times, benefiting our residents and patients.

Executive Compensation *

The hospital has only one executive position; namely the Executive Director (ED). The ED is the chief administrator of both the hospital operating 58 CCC beds and a long-term care operation of 150 beds. A percentage of the annual base of the ED (3%) as determined by the Board of Directors, is linked to the achievement of targets set out in the QIP.

Contact Information

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(https://www.hqontario.ca)

(https://twitter.com/HQOntario)

(https://www.youtube.com/user/HealthQualityOntario)

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SUBMIT QIP

~~WORKPLAN~~ ~~PROGRESS~~ REPORT | ~~NARRATIVE~~ | Workplan

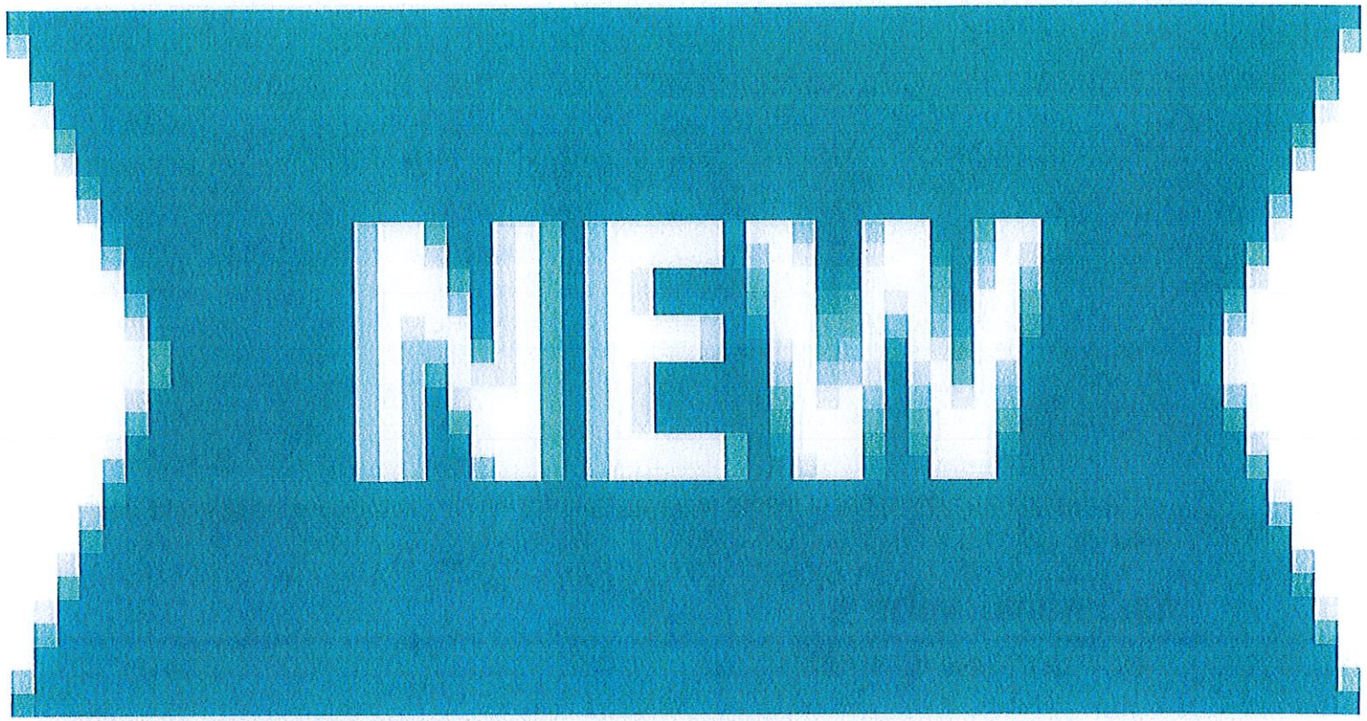
2020/21 Quality Improvement Plan

Hotel Dieu Hospital - Cornwall

Status: SUBMITTED

To enter data in the Workplan, click on the cell or the "Add" button. In the Measure/Indicator column, the indicators that appear in red font are the priority indicators.

Organization: View All



EXPORT WORKPLAN EXPORT EXTERNAL COLLABORATION REPORT

PREVIOUS FORMAT : CURRENT WORKPLAN BLANK WORKPLAN TEMPLATE

ID AIM	MEASURE									CHANGE				
QUALITY DIMENSION	MEASURE / INDICATOR	TYPE	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	EXTERNAL COLLABORATORS	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	TARGET FOR PROCESS MEASURE	COMMENTS

ℹ 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

ID	AIM	MEASURE									CHANGE				
	QUALITY DIMENSION	MEASURE / INDICATOR	TYPE	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	EXTERNAL COLLABORATORS	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	TARGET FOR PROCESS MEASURE	COMMENTS
1	Efficient	Total number of alternate level of care (ALC) days contributed by ALC patients within the specific reporting month/quarter using near-real time acute and post-acute ALC information and monthly bed census data.	P	Rate per 100 inpatient days / All inpatients	WTIS, CCO, BCS, MOHLTC / Jul 2019 - Sep 2019	644	12.00	9.00	We are slightly above our projected target of 11.00 however we have appointed a .5 Social Worker to the rehab program who continuously monitors ALC beds and collaborates with a LHIN Home and Community Case Worker. Together they explore all viable options for our ALC patients such as, monitoring for idle bed activity within our region and act promptly on these opportunities as they arise.	Champlain Local Health Integration Network	#1) Our Social Worker and LHIN representative continue to keep track of and monitor options for appropriate discharge destinations and act on them as they become available. More challenging discharges are reviewed with the team at the bi-weekly Bullet Round meetings and options are discussed at this level as well. Bed flow Coordinator along with the entire team review all new referrals to ensure they are appropriate for the rehab program and ensure there is a suitable, safe discharge destination in place whether it be returning home or to a retirement home in the community.	S/W and LHIN case worker review the bed flow activity in the region via the LHIN portal on a daily basis. S/W keeps lines of communication open with all ALC patients and their families, providing them with updates to discharge planning to reduce anxiety.	Interdisciplinary team will continue to review referrals for admissions daily to ensure they are the appropriate candidates for the slow paced rehabilitation program. Discuss ALC pt's status and updates during Bullet Rounds with Interdisciplinary team twice weekly.	12.0 percent is the rate of inpatient days overall.	Despite the fact that we did not quite meet our target we have been showing steady improvements in reducing our ALC numbers.
2	Efficient	Unconventional spaces	P	Count / All inpatients	Daily BCS / TBD	644	0.00	0.00	Not completing this indicator		#1) Not completing this indicator	Not completing this indicator	Not completing this indicator	Not completing this indicator	Not working on this indicator
3	Efficient														

ID AIM	MEASURE									CHANGE				
QUALITY DIMENSION	MEASURE / INDICATOR	TYPE	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	EXTERNAL COLLABORATORS	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	TARGET FOR PROCESS MEASURE	COMMENTS
	Number of ED visits for modified list of ambulatory care sensitive conditions* per 100	C	Rate per 100 / All inpatients	In house data collection / January 2020-December 2020	644	59.00	45.00	We are in the early stages of measuring this metric.		#1) Develop a Task Force committee to review data for ED transfers with the goal of identifying trends and the rationale for each transfers to determine if any could have been avoided.	Nursing Care Coordinator (NCC) will maintain a log of all ED transfers, identifying any patients with comorbidities placing them at a higher risk for ED transfers. The log will also track times of transfers, staff members who arranged transfer. Nursing Care Coordinator will review stats on a monthly basis with other key members of the care team to discuss challenges met and ways in which we can improve on. Case based learning strategies will be developed for registered staff to improve confidence in their assessments and critical thinking skills. NP will explore algorithms which are currently available to assist registered staff in making decisions for transfer based on trajectory of symptoms present.	100 percent of ED visits will be reviewed and analyzed on an ongoing basis by the NCC and the information gathered will be shared with Multidisciplinary Team members on a monthly basis. This indicator will also be added as a standing item for discussion at the monthly Professional Advisory Committee. 2. Registered staff will be invited to attend lunch and learn sessions which will include case studies related to avoidable ED transfers. The presentation slide deck from learning modules on these case studies will be made available to all registered staff for their review on our internal Intranet system.	100 percent of ED transfers will be reviewed and those which were deemed preventable will be flagged for discussion with other key members of the team.	We strive to continue on improving this metric and feel our target is achievable with the new processes which will be implemented.

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										#2) Early recognition of exacerbation of symptoms and timely interventions for patients deemed at higher probability of being transferred to ED due to a specific diagnosis.	All patient referrals sent for admission consideration will be reviewed by the Bed Flow Coordinator and Care Team. Patients with comorbidities and conditions identified as putting them at higher risk for avoidable ED transfers such as CHF and COPD, will be monitored closely for exacerbation of disease so that it can be treated effectively in a timely manner.	Referrals will be reviewed daily and flagged accordingly.	100 percent of referrals will be reviewed and patients with conditions that require closer monitoring to prevent exacerbation of disease will be identified and a plan of care will be put into place.	We recognize that many patients admitted into our rehab program have medical conditions and comorbiditi es which could put them at higher risk for transfers to the ED. Early detection and interventio n concerning symptom managem ent is key in preventing these ED transfers.

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4	Efficient	The rate at which the patients achieve their Expected Date of Discharge (EDD).	C	% / Discharged patients	In house data collection / January 2020-December 2020	644	85.00	90.00	In 2019 we had successfully discharged 85% of our rehab patients within the predicted EDD time-frame as pre-determined by their admission diagnosis.		#1) Barriers to discharge will be identified early on through the assessment process and will be reviewed with the team during Bullet Rounds every week until interventions are in place to so that these barriers can be in timely manner so that it does not impact the determined EDD.	The Estimated Discharge Date and Outreach Health Links assessments in Point Click Care upon admission; which can help to identify any barriers to discharge which can be followed up with promptly. EDD dates are reviewed weekly with the multidisciplinary team on a weekly basis to ensure the date remains appropriate.	% of patient's who have received a EDD and were discharged on or before the projected date.	90 percent of the patients will achieve success with their EDD goals	
5	Timely	Percentage of patients discharged from hospital for which discharge summaries are delivered to primary care provider within 48 hours of patient's discharge from hospital.	P	% / Discharged patients	Hospital collected data / Most recent 3 month period	644	CB	CB	Not completing this indicator,		#1) Not completing this indicator.	Not completing this indicator.	Not completing this indicator.	Not completing this indicator.	Not completing this indicator.
	THEME II: SERVICE EXCELLENCE														
6	Patient-centred	Percentage of complaints acknowledged to the individual who made a complaint within five business days.	P	% / All patients	Local data collection / Most recent 12 month period	644	CB	0.00	Not measuring this indicator.		#1) Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.

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7	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?	P	% / Survey respondents	CIHI CPES / Most recent 12 months	644	CB	CB	Not working on this indicator.		#1) Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.
	THEME III: SAFE AND EFFECTIVE CARE														
8	Effective	Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	P	Rate per total number of discharged patients / Discharged patients	Hospital collected data / Oct 2019– Dec 2019 (Q3 2019/20)	644	100.00	100.00	Not working on this metric.		#1) Not working on this metric.	Not working on this metric.	Not working on this metric.	Not working on this metric.	Not working on this metric.

ID	AIM	MEASURE									CHANGE				
	QUALITY DIMENSION	MEASURE / INDICATOR	TYPE	UNIT / POPULATION	SOURCE / PERIOD	ORG ID	CURRENT PERFORMANCE	TARGET PERFORMANCE	TARGET JUSTIFICATION	EXTERNAL COLLABORATORS	PLANNED IMPROVEMENT INITIATIVES (CHANGE IDEAS)	METHODS	PROCESS MEASURES	TARGET FOR PROCESS MEASURE	COMMENTS
9	Effective	Percent of unscheduled repeat emergency visits following an emergency visit for a mental health condition.	P	% / ED patients	CIHI NACRS / April - June 2019	644	0.00	0.00	Not completing this indicator.		#1) Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not completing this indicator.
10	Effective	Proportion of hospitalizations where patients with a progressive, life-limiting illness, are identified to benefit from palliative care, and subsequently (within the episode of care) have their palliative care needs assessed using a comprehensive and holistic assessment.	P	Proportion / All patients	Local data collection / Most recent 6 month period	644	CB	CB	Not working on this indicator.		#1) Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.	Not working on this indicator.
11	Safe										**#1) Education component- All new and existing employees receive GPA training. Workplace Violence is reviewed with all new hires during General Orientation**	**Continue to offer GPA courses and/or a refresher course to all new and existing employees in order for staff to feel prepared and to assist them in maintaining their**	**Record number of workplace violence incidents per year.**	**We will strive to maintain our current level of 0 incidents.**	**FTE=88 Sustaining our current success will be key.**

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	Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period.	MANDATORY	Count / Worker	Local data collection / Jan - Dec 2019	644	0.00	0.00	To sustain our current level of success.		and is also reviewed annually, during mandatory employee education sessions. A fulsome review of all workplace violent incidents is discussed during bi-monthly Leadership meetings.	safety when faced with incidents of workplace violence. Patient's with a history of violent tendencies are flagged on the demographic page and face page on their medical chart in order to alert staff of potential dangers. Security cameras were installed throughout the facility in public common areas and on the property grounds. Personal Mini Alarm keychains were provided to all employees as a safety measure to alert co-workers of an emergency situation in the event they are unable to access the call bell. Code Silver policy (suspicious person with weapon) was implemented in 2019. Drills have been instrumental in familiarizing staff with their expected			

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												roles and responsibilities during a code silver event.			
	EQUITY														
12	Equitable														