Ontario Health

## Quality Improvement Plan (QIP)

# Narrative for Health Care Organizations in Ontario

July 8, 2022

CENTRE DE SOINS PROLONGÉS
ST. JOSEPH'S
CONTINUING CARE CENTRE

## OVERVIEW

St. Joseph's Continuing Care Centre (SJCCC) is a non-profit organization located along the scenic St. Lawrence River in Cornwall Ontario. The land on which St. Joseph's operates includes the territory of the Haudenosaunee and Algoniquin peoples. SJCCC is grateful for the opportunity to work and live on this land and remain committed to, and acknowledge responsibility for building and improving relationships with First Nations, Inuit, and Metis peoples as equal partners in all we do. SJCCC is owned and operated by the Religious Hospitallers of St. Joseph's (RHSJ). This unique facility houses a 150 bed Long-Term Care home- referred to as St. Joseph's Villa (SJV), and a small 58 bed hospital- known as Hotel Dieu Hospital (HDH). St. Joseph's Continuing Care Centre is proud to be accredited by CARF International and is also affiliated with Catholic Health International (CHI).

This year SJCCC celebrated a special milestone commemorating the 125 year Anniversary of the Religious Hospitallers of St. Joseph's arrival to Cornwall. The Sisters came to the city to establish and operate Cornwall's very first hospital. Hotel Dieu Hospital opened its doors to the public in June of 1897. For more than a century the Religious Hospitallers of St. Joseph served in our community, never failing to recognize the needs of the sick, the elderly and very young. Their legacy of holistic and compassionate care remains deeply rooted and is reflected in our Mission, Vision and Values Statements. 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 within our small hospital include, Slow Paced Rehabilitation (Restorative Care), Medically Complex Care and Remote Care Monitoring. Restorative Care is a progressive, dynamic, goal oriented program with the purpose of improving one's functional ability and working towards facilitating a safe discharge home or to another supportive setting. The length of stay varies from a minimum of 2 weeks to a maximum of 90 days. Therapy sessions are tailored to the individual needs and rehabilitation goals. Many patients transitioned over to our slow paced rehab program from acute-care post to continue their recovery post COVID-19 for strengthening and reconditioning. The Remote Care Monitoring (RCM) project was piloted in the summer of 2020, this program was an enhancement and an extension to our rehabilitation program already in place. Patients are monitored virtually with the use of a mobile app for up to 30 days post discharge by our healthcare team to ensure their transition home is safe and manageable. This program has been instrumental in preventing many unplanned ED visits and re-admissions to hospitals that can occur soon after discharge from the program.

For the 2022-23 Quality Improvement Plan we will focus our efforts under the dimensions of Timely and Patient-centred.

Under the theme "Timely", we will review and evaluate the percentage of discharge summaries sent from hospital to primary care providers within 48 hours of discharge.

Under the Patient experience dimension we will review whether patients felt they received adequate information about their health and their care at discharge.
Under the same dimension, We will also explore whether patients felt involved in decisions about their care. We also reviewed the percentage of avoidable ED visits from our Slow Paced Rehabilitation program that occurred under the "Efficient" dimension.

## REFLECTIONS SINCE YOUR LAST QIP SUBMISSION

St. Joseph's Continuing Care (SJCCC), as with so many other hospitals experienced unprecedented challenges navigating through unknown pandemic territory, with having never experienced a pandemic before. The health, safety and well-being of our residents, patients and healthcare providers remains our priority and focus to this day.

Despite the fact that we were in the midst of a global pandemic, SJCCC continued to explore opportunities and QI initiatives that would improve patient outcomes and quality of life. In July of 2020 SJCCC embarked on a pilot project initiative that was a first in Ontario, titled Remote Care Monitoring (RCM). This program refers to a model of care in which clinical teams and health care providers remotely support a patient's plan of care via virtual tools. SJCCC recognized RCM as being a strategic priority and an innovative model that would complement our inpatient hospital program already in existence. A partnership was developed with Ontario TeleMedicine Network (OTN) with the goal to provide support through Remote Care Monitoring for a period of 30 days post discharge to our Slow Paced Rehab population at no cost to the patient. The program focuses on health teaching, medication management, falls prevention, nutrition, personal hygiene and wellness checks. The RCM program goals are inline with the Ontario Health Team vision with keeping seniors safely in their homes for as long as possible.

Benefits of the RCM Program:
RCM offers the ability to oversee and support local and geographically dispersed patients during their first 30 days post-discharge, which is considered to be the period of heightened risk.
ED visits were notably decreased.
Empowers patients and boosts self confidence thereby improving the overall patient experience.
Engages patients and improves adherence to post-discharge recommendations.
Ensures a smooth transition and warm hand-off with our partners who are providing care in the community.

The discharge plan is customized for each patient and has the capability to include:
Daily check-ins via tablets with patients and family members and sends reminders and instructional cues regarding health testing and/or medication management.
Monitoring of vital-signs via Bluetooth devices; alerts are forwarded to the RCM team when discrepancies are detected with vital signs or in patient's overall condition, thus allowing for more timely interventions.

Patients have access to condition-specific health teaching content and videos through this format as well.

During the first year in operation the RCM program successfully transitioned 120 patients through their initial post discharge phase. 91% of participants indicated they had experienced less need to visit the emergency department as a direct result of the support and guidance they received from the RCM program.

Other improvement initiatives that were incorporated over the course of the past two years surrounded the implementation of virtual platforms. A virtual format was adopted facility-wide with the assistance of the IT team by setting up additional computers, devices and headsets on all units to improve communications, which aided in maintaining the day to day operations within the Centre. All communications were held via virtual platforms such as Resident Care Conferences; Multidisciplinary meetings; employee interviews; educational in-services; staff meetings and annual education to name but a few.

SJCCC underwent the CARF Canada Accreditation process which was held virtually due to the pandemic. Our organization was granted a three year accreditation with no recommendations, which is only achieved in 3% of CARF surveys.

As we move into the recovery period from the effects of the pandemic, St. Joseph's Continuing Care Centre feels confident that we will continue to make substantial gains and improvements with QI initiatives and goals.

## PATIENT/CLIENT/RESIDENT PARTNERING AND RELATIONS

We are fortunate to have many platforms for advocacy and collaboration at SJCCC. The voices of those we work with and care for are foundational in providing the highest quality of care. With regular meetings, follow-ups and shared ideas, we are able to work together as a team to provide excellence, innovation, safety and holistic approaches to care. The sharing of lived experiences allows us to work on continuous quality improvement in our Long Term Care, rehabilitation, palliative care and remote care services.

Resident, Patient and Family surveys were completed. The information received from surveys is invaluable and important in determining areas where improvements need to be made.

## PROVIDER EXPERIENCE

This pandemic proved to test all the boundaries, however, with adversity comes resilience and despite the fact that we are still experiencing some of the rippling effects from COVID-19, we all hang on to the hope that the worst is finally behind us. Staff from every department within our organization proved that when "the going gets tough, the tough get going". Our front-line staff members are truly the definition of "Healthcare Heroes" and this has been a constant throughout each wave. Staff were guided by the Centre's Mission statement,that reads, “In the spirit of the Religious Hospitallers of St. Joseph, we reveal God’s love and mercy through compassionate care focused on the body, mind and soul of all those whose lives we touch.” These words resonated deeply

within our staff, as evidence by their outpouring of compassion, dedication and quality of care they continued to provide to their patients, all while navigating through challenging and demanding situations caused by increased workload, dealing with multiple outbreaks and the pressures of isolation protocols. Staff were attentive to the patients' needs offering support and comforting measures when family members were no longer permitted entry into the hospital due to visitation restrictions. Home life issues were present for some as well with gaps in childcare, family illnesses, school closures and homeschooling demands.

Fostering a positive, safe and healthy work environment for all our SJCCC employees is important. Workplace Wellness newsletters are posted on a quarterly basis. Information is geared towards health, safety and improving work-life balance. Fresh fruit, healthy snacks, and beverages were provided for staff to acess free of charge in the Cafe. Staff were also provided with meals and snacks when working during isolation phases. EAP is available and encouraged for all staff to access.

Staff Appreciation days were held frequently as a means to show our gratitude. Employees were treated with pizza and breakfast meals served by the Leadership team. Raffles for gift cards and other prizes donated by our Board Members and other sponsors were held. Parking fees for all employees were waived during the pandemic.

Our annual Sister Rosalia Cobey Award ceremony was held virtually this year after a short hiatus. Seven exemplary employees were nominated by their peers for this prestigious award.
Employee Service Awards were also held virtually. A total of 48 valued employees were recognized and praised for reaching milestone years of service ranging from five to forty years.
SJCCC is committed to providing a positive, safe and healthy work environment for our employees.
Board Members were very supportive of the Centre and staff over the course of the pandemic, showing their appreciation by generously donating gifts and gift cards for raffles and draws.

SJCCC is proud to be an integral part of the Ottawa East Ontario Health Team (OHT). The team collaborates with providers from Eastern Ontario, Eastern Champlain and part of the Ottawa region. We also work closely with our partners from Cornwall Community Hospital, Home and Community Care Support Services. SJCCC is proudly affiliated and sponsored by Catholic Health International.

## 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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## 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 _____

_____
Board Chair

_____
Board Quality Committee Chair

_____
Chief Executive Officer

_____
Other leadership as appropriate

_____

# Theme I: Timely and Efficient Transitions

## Measure

**Dimension:** Efficient

| Indicator #1 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Number of ED visits for modified list of ambulatory care–sensitive conditions* per 100 patients in Slow Paced Rehab Program. | C | Rate per total number of admitted patients / Rehab | CIHI CCRS, CIHI NACRS / October 2020-September 2021 | 34.80 | 30.00 | We exceeded our projected outcome and would like to continue to focus our efforts in further reducing this metric. | |

## Change Ideas

Change Idea #1 Audit and review all ED transfers to determine those that were avoidable based on the case-sensitive conditions identified for patients 65+ years of age.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Quality Lead to log/review all ED transfers. Discuss any cases where transfers were deemed preventable during weekly Hotel Dieu Task Force Meetings. 2. Identify trends noted- ie) times of transfers; sending physician (primary vs on-call physician) and also experience of staff (junior staff vs experienced staff). | Track and measure number of ED visits deemed potentially avoidable for all residents 65 years and over according to the list of care-sensitive conditions identified. | 100 percent of all ED visits will be tracked and analyzed for trends in order to further improve our current processes. | |

Change Idea #2 Increase patient/SDM awareness on the potential health risks associated with ED transfers at the time of admission.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| MD/NP to provide health teaching to patients and Substitute Decision Maker on risks associated with transfers to ED and potential hospitalization such as, increased risk for pressure ulcers, increased incidence of delirium, increased risk of contracting nosocomial infections and ARO's. 2. Medical Staff to review Rockwell Clinical Frailty Scale and RAI CHESS scores with permanent patients/SDM and short stay patients experiencing significant changes to their health and condition. | % of patients/SDM who received information on reducing ED transfers enabling them to make an informed decision. | 50% of patients/SDM will receive information regarding preventing ED visits upon their admission. | This is a new initiative. |

Change Idea #3 Implement falls strategies at the time of admission to prevent ED transfers associated with falls.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Quality Lead to review fall incidents in PCC Risk Management and maintain tracking log. 2. Registered staff to identify comorbidities placing them at higher risk for falls. 3. Falls care plan to be implemented upon admissions. 4 Complete MORSE falls assessment on admission to determine risk of falls. 5. Staff to liaison with OT/PT to implement falls prevention strategies for patients experiencing increased incidents of falls. | The # of falls that occurred resulting in injuries, prompting ED transfers. | 100% of falls will be reviewed and tracked by Quality Lead | This is a new initiative. |

## Measure

**Dimension:** Timely

| Indicator #2 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| 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 | 3.00 | 50.00 | Baseline for this target. | |

## Change Ideas

Change Idea #1 Improve the process for completion of discharge summaries in a more timely manner and documents to the primary providers.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| 1. Implement auditing process by reviewing patient medical charts and cross referencing the date of discharge against the date of which the discharge summary report was dictated. Audit to determine whether the delay was due to physician not completing discharge summary on time vs a delay in forwarding the documents by clerical staff. 2. Explore electronic discharge summary options with IT that would enable a more efficient method for completing d/c summaries. 3. Explore options with IT for physicians to submit completed discharge summaries electronically to primary physicians for efficiency rather than via fax. 4. Explore options available with IT that would forward electronic reminders to physicians alerting them when a patient has been discharged and discharge summaries are due. | Track the turn around time for completion of discharge summaries and the time for which documents are faxed to the primary care providers. | A 50% improvement in completion of discharge summaries within 48 hours from date of discharge will be achieved by Q3. | This is a new indicator for our organization. |

Change Idea #2 Improve gaps with forwarding and distribution of discharge summaries to primary care providers upon discharge.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Conduct monthly chart audits-cross reference discharge summary completion dates as compared to the dates when discharge summaries were faxed. | Review current process with team to determine best method with forwarding the discharge summaries to primary physicians in a timely manner. | 50% improvement will be noted by Q3. | This is a new indicator for our home this year. |

# Theme II: Service Excellence

## Measure

**Dimension:** Patient-centred

| Indicator #3 | Type | Unit / Population | Source / Period | Current Performance | Target | Target Justification | External Collaborators |
|---|---|---|---|---|---|---|---|
| Percentage of patients who indicated they were always or often involved in their care decisions when they saw their doctor or nurse practitioner. | C | % / All patients | In-house survey / April 2021-March 2022 | 62.90 | 70.00 | Previous year result for this survey question was higher at 77.4% compared to 62.9% this year. Goal is to increase this response to 75%. | |

## Change Ideas

Change Idea #1 Improving patient engagement to improve pt satisfaction and outcomes.

| Methods | Process measures | Target for process measure | Comments |
|---|---|---|---|
| Patient/Family Relations Advisor to discuss with the patient the level of involvement they expect. Develop Task Force to initiate Patient Engagement strategies to incorporate. | Percentage of patients who indicated they always or often were involved in decisions of care. | Increase performance by 10% | Of the 35 surveys that were completed- 22 patients responded "Always" or "Often" involved in the decisions for their care. |