Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 16, 2023

Ontario Health

OVERVIEW

St. Joseph's Continuing Care Centre (SJCCC) is a not for profit organization, accredited by CARF International and located along the St. Lawrence River in Cornwall, Ontario. The land on which SJCCC operates includes the territory of the Haudenosaunee and Algonquin 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. Owned and operated by the Religious Hospitallers of St. Joseph's (RHSJ), our unique facility houses two separate programs under one roof and offers services in the following areas: 150 provincially licensed long-term care beds, referred to as, St. Joseph's Villa (SJV); and a small 58-bed hospital known as Hotel Dieu Hospital (HDH).

Last year, SJCCC celebrated a special milestone commemorating the 125th year anniversary of the RHS's arrival to our 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 RHSJ Sisters served our community, never failing to recognize the needs of the sick, the elderly and the very young. The Sister's legacy of holistic and compassionate care remains deeply rooted and is reflected in our Mission, Vision and Value statements. We continue to lead by their example and remain committed to improving the life of our seniors affected by loss of autonomy through illness or injury.

Services that are offered through Hotel Dieu Hospital include: Slow-Paced Rehabilitation, Medically Complex Care and Remote Care Monitoring. Slow-Paced Rehab is a progressive, dynamic, goal-oriented program with the purpose of improving one's functional

ability while working towards facilitating a safe transition to home or to another supportive community setting such as retirement living.

The Remote Care Monitoring program (RCM) was piloted in the summer of 2020 and is now in its 3rd year of operation. This program is essentially an enhancement and extension to our rehabilitation program. Patients are monitored virtually up to 30 days post discharge with the use of Bluetooth-connected health devices from the comforts of their home. Our healthcare team ensures the patients transition to home is a safe and manageable one. This program has been instrumental in preventing many unplanned ED visits and re-admissions to hospital post discharge. The first year in operation the RCM program admitted 94 patients onto their virtual ward; it is estimated that by the end of this fiscal year, 400+ patients will have been admitted.

During the height of the pandemic, SJCCC was granted a prestigious three-year accreditation with no recommendations through CARF International. This distinction is only awarded in 3% of CARF surveys.

Construction for a state of the art gym/therapy space is slated to commence this spring.This space will provide the patients and residents at our Centre the opportunity to engage and participate in exercise programs and therapy sessions that are geared to their individual needs.

A separate QIP report has been created for the LTC and HDH programs.

For our HDH program, the goals for the year 2023-24 will focus on the following modalities:
1. Under the "Timely" theme, we are continuing to monitor and evaluate the percentage of discharge summaries sent from hospital to the patient's primary care providers (PCP) within 48 hours of discharge.
2. Under the patient experience dimension we are continuing to review and explore whether patients felt involved in decisions about their care when they spoke with their MD/NP.
3. Under he "Efficient" dimension we are continuing to review and monitor the percentage of potentially avoidable ED visits.

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: Timely

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of discharge summaries sent from hospital to community care providers within 48 hours of discharge.	C	% / Discharged patients	In house data collection / Quarter 3	21.00	50.00	While we have made improvements in this area, we did not achieve our target of 50% completion of D/C summaries within 48 hours of discharge. It is anticipated with the strategies put in place and new interventions we will add will yield a more positive result with this metric.	

Change Ideas

Change Idea #1 Continue to work on interventions for more timely completing and forwarding discharge summaries upon discharge to primary care providers.

Methods	Process measures	Target for process measure	Comments
Maintain and update google documents for each MD/NP with a list of patients'names discharged from the program on the day of discharge as a reminder that a discharge summary is due.	Number of MD's/NP's receiving reminders that a discharge summary is due.	100% of MD's/NP's will receive reminders that a discharge summary is due.	Google documents have been created and this has yielded some positive results. We anticipate this intervention we will continue to make improvements for this metric going forward.

Change Idea #2 Continue with current process of auditing and monitoring discharge summary completion times and communicate results with key stakeholders.

Methods	Process measures	Target for process measure	Comments
Provide updates on d/c summary completion on a monthly Professional Advisory Committee (PAC) meetings to discuss areas of concern and obtain feedback. Provide quarterly results of this stat during PAC as well.	Sharing of relevant information with the Physicians and Nurse Practitioners to improve outcomes.	100% of physicians and NP's will be provided with D/C summary updates and relative information every month.	

Change Idea #3 Reduce the gaps with forwarding and distributing of discharge summary reports to PCP.

Methods	Process measures	Target for process measure	Comments
Implement email reminders to providers indicating outstanding D/C summaries that are still in queue and those still in draft mode requiring authorization.	The number of physicians/NPs receiving email reminders of an incomplete	100% of providers will receive email reminders to alert them when a d/c summary is in draft mode and when summaries are overdue.	This process will commence in Q1.

Measure

Dimension: Timely

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of ED visits for modified list of ambulatory care sensitive conditions* according to Health Quality Ontario per 100 patients in the Slow Paced Rehab Program.	C	% / Rehab	In house data collection / Over 3 quarters (Q 1-3) -Year 2022	59.70	40.00	Target not met. A significant increase to ED transfers was noted during the quarters identified as compared to previous performance of 34.8%. Contributing factors were related to COVID-19 outbreaks on the units along with mefically unstable pt's with comorbidities requiring transfers to acute care.	

Change Ideas

Change Idea #1 Continue with the current process of reviewing all ED transfers to determine those that are considered avoidable based on HQO's case sensitive conditions for patients who are 65+ years.

Methods	Process measures	Target for process measure	Comments
1.Quality lead reviews and logs all ED transfers. Discussions are held during weekly Task Force Meetings and monthly Professional Advisory Committee concerning those that were avoidable. 2.Data is analyzed for trends ie) Reason for transfer, time of transfer, sending physician (primary vs on-call). Emergency transfers. Level of experience with registered staff sending (new hires vs experienced).	1. Percentage of ED transfers that were considered avoidable. 2. Trends to transfers.	100% of ED transfers will be tracked and analyzed for trends.	Falls accounted for 31% of patient transfers to ED during this review.

Change Idea #2 Individualized plan of care outlining level of risk for falls and strategies for falls prevention to be completed on day of admission.

Methods	Process measures	Target for process measure	Comments
Complete MORSE Fall Scale on admission to identify the level of risk for falls. Staff to liaison with the OT/PT to implement fall prevention strategies for patients identified to be a mod/higher risk. Provide all patients with anti-slip socks on admission.	Number of patients who have had a fall assessment and fall care plan focus in place on the day of admission	100% of patients will be assessed along with strategies for falls prevention in place.	

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 2022-March 2023	62.90	70.00	To achieve the previous result of 75.0%. Survey results for 2022/23 are not yet available. 62.90% was the result from the in-house survey taken in 2021/2022.	

Change Ideas

Change Idea #1 Improve patient engagement in decisions with their care to improve patient satisfaction and outcomes.

Methods	Process measures	Target for process measure	Comments
Patient Family Relations Advisor asks the pt/family the level of involvement they prefer regarding their care-decisions during post admission meetings. A level of low- medium or high involvement is entered onto the pt's chart under patient profile for providers to access.	Percentage of patients who indicated they are always or often involved with their care decisions.	Remains at 70.0%	Survey results for 2022/23 are not yet available. 62.90% was the result from the in-house survey taken in 2021/2022.

Change Idea #2 To enhance patient engagement and communication with their MD/NP regarding their care decisions.

Methods	Process measures	Target for process measure	Comments
Labels titled, "Questions for my Doctor/NP" were added to whiteboards at the bedside for patients and family members to write down questions or concerns they want to discuss with their medical provider during rounds.	Number of patients who utilize this method as a means of communicating with their MD/NP. Currently collecting baseline.	Collecting baseline.	