# 2023/24 Quality Improvement Plan
# "Improvement Targets and Initiatives"

## HOSPITAL

Niagara Health System 1200 Fourth Ave, St. Catharines , ON, L2S0A9

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| AIM | | Measure | | | | | | | | | Change | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Issue | Quality dimension | Measure/Indicator | Type | Unit / Population | Source / Period | Organization Id | Current performance | Target | Target justification | External Collaborators | Planned improvement initiatives (Change Ideas) | Methods | Process measures | Target for process measure | Comments |
| M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) A= Additional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on) | | | | | | | | | | | | | | | |
| **Theme II: Service Excellence** | **Patient-centred** | Patient Experience - Safe Discharge: Did patients feel that they received adequate information about their health and their care at discharge. | C | CB / Discharged patients | CB / CB | 962* | | | Collecting Baseline Data | | 1) Implementing a process to collect emails at registration | Building the process in the system to capture emails<br><br>Training and educating staff on email collection process | % of eligible patients that are registered are asked for their email<br>Monitoring the return rate to meet industry benchmarks | 100%<br><br>100% | |
| | | | | | | | | | | | 2) Monitor survey return rate to ensure reaching industry benchmark | Monthly monitor number of emails gathered<br>number of emails declined | # of discharges eligible to receive survey<br># of emails received and declined from eligible patients | Reach return rate levels identified by OHA document per type of survey | |
| | | | | | | | | | | | 3) External communications to promote patient participation | Develop education plan and content to inform patients and the community about the patient experience survey | # of social media clicks<br># of website visits | Baseline capture | |
| **Theme III: Safe and Effective Care** | **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–Dec 2022 (Q3 2022/23) | 962* | 78.28 | 82.60 | To achieve a 4.34% improvement over 2022/23 target. | | 1) Review current process and assess its variability in practice | Complete process mapping to assess the current variability in process | Process map completed each program at each site | Completed process maps for surgery, medicine and W&B at SCS, WS and NFS | |
| | | | | | | | | | | | 2) Understand the barriers to adoption among all staff and physicians involved in the process | Complete root cause analyses to identify barriers and develop recommendations for improvement<br><br>Implement process improvements to address barriers | Recommendations developed with goals, measurement and implementation plan<br><br>Each program will choose a target to meet every quarter starting with the physicians with the highest volumes of discharge | Plan developed by Sept 2023<br><br>Each program maintains or improve compliance by 5% per quarter | |
| | **Safe** | Number of workplace violence incidents reported by hospital workers (as defined by OHSA) within a 12 month period. | C | Count / Worker | Local data collection / Jan 2022–Dec 2022 | 962* | | | Collecting Baseline Data | | 1) Improve the accuracy of security reporting of violent incidents via IRS | Review the process with the security team to understand barriers<br><br>Implement process improvement for reporting | Meetings occur with barriers identified<br><br># of incidents reported by security | Baseline capture | |
| | | | | | | | | | | | 2) Vocera badges for all patient facing staff | Staff education campaign<br><br>Update the training module to increase their understanding of how to log into the system | Materials developed<br># of staff educated<br># of staff wearing badge | 100% compliance for badge wearing | |
| | | | | | | | | | | | 3) Increase knowledge of violence prevention tools | Violence prevention training including how to report incidents is included in clinical staff training days | # of staff educated | Baseline capture | |

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| Equity | Equitable | Equity/Cultural Sensitivity: Total number of Leaders who complete an on-line learning module regarding Cultural Sensitivity for Indigenous Peoples. | C | % / Leaders | In house data collection / January - December 2023 | 962* | 20.7 | 100.00 | To achieve a 100% compliance rate | | 1) Creation of learn module for Indigenous cultural safety training | Develop the training module with input from the Indigenous community partners | Content is created | Created and available to staff by Sept 2023 | |
| | | | | | | | | | | | 2) Implementation of training module to all leaders | Training module available through learning management system | # of managers trained | 100% of leaders trained | |
| | | Equity/Cultural Sensitivity: Total number of New Hires who attend an introductory session at orientation on Diversity and Cultural humility approach | C | % / New Hires | In house data collection / January-December 2023 | 962* | 73.9 | 100.00 | To achieve a 100% compliance rate | | 1) Updating module with feedback from the Indigenous Health Services Team | Gather feedback from Indigenous Health Services Team and incorporate into module | Feedback gathered from Indigenous Health Services Team and incorporate into module | Module completed by July 2023 | |
| | | | | | | | | | | | 2) Ensure all new hires receive training through general orientation | Add content to general orientation for all new hires | Content is added<br># of new hires that receive training | 100% of all new hires | |
| | | Equity/Cultural Sensitivity: Total number of new Clinical Hires who attend a session on Cultural Humility at General Nursing Orientation | C | % / New Clinical Hires | In house data collection / January - December 2023 | 962* | 49.7 | 100.00 | To achieve a 100% compliance rate. | | 1) Updating module with feedback from the DEI committee | Gather feedback from the DEI committee and incorporate into module | Feedback gathered and incorporate into module | Updated by July 2023 | |
| | | | | | | | | | | | 2) Ensure all new hires receive training through General Nursing Orientation | Add content to general orientation for all new nurse hires | Content is added<br># of new hires that receive training | 100% of all new hires | |