2025/26 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

Hospital

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Progress Report

Aim		Measure												Change					Progress Towards Implementation of Change Ideas			Revised (NEW) change ideas that was not included in last year's Workplan				
Quality Dimension	Issue	Measure/Indicator	Type - Mandatory - Priority - Additional - Custom - Optional	Unit of Measure / Population	Data Source / Period	Organization Id	Current performance	Target	Target Justification	Is this indicator related to Emergency Department Return Visit Audit?	Is this indicator related to Executive Compensation?	Is this indicator related to part of the 2025/26 Pay-for-Results (P4R) Action Plan?	External Collaborators	Planned Improvement Initiatives (Change Ideas)	Indicator (Options) - We will not be working on this indicator! - We are performing well on this indicator (i.e., above provincial average) - We have included a custom indicator related to this theme! - We are prioritizing other areas of focus! - Other!	Methods	Process Measures	Target for process measure	Comments	Overall Progress on Change Idea	Progress on Process Measure	What were your successes and/or challenges? Share the results of your processmeasures Comment on barriers and/or enablers that impacted your initiatives	Description of change idea	Overall Progress on Change Idea	Progress on Process Measure	What were your successes and/or challenges? Share the results of	Additional comments and plans for future improvement
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), O = Optional																										
Timely	Access and Flow Timely	90th Percentile ambulance offload time. Ambulance offload time is the duration (time elapsed) between the time of ambulance arrival at the emergency department and the time the ambulance transfer of care process is complete.	P = Priority	ED patients	Hospital collected Data		Jan/25 to Dec/25 Met: 97 mins	90 minutes	The target focuses on a step-wise improvement towards the provincial benchmark of 90 minutes.	Yes	No	Yes	Niagara EMS	Scale and Spread FIR250 improvements to remaining 2 sites.		Identify factors to support the spread of the FIR in each site through process mapping, reviewing and sharing lessons learned from other sites and subsequently develop action plans for implementation.	% of eligible FIR patients identified and part of the program within 30 minutes of triage # of NH staff & EMS paramedics educated on the FIR program Ambulance Offload Time (AOT) of FIR250 pts Ambulance Offload Time (AOT) of all pts at 90th percentile	100% Niagara EMS & ED Staff educated on the FIR program 85% Eligible FIR pts are identified and part of program within 30mins of triage. 90 Minutes AOT of FIR patients		Implemented	Improved but not met	Implemented at all sites and continued efforts to make improvements.					
														Explore the potential for the implementation of a Horizontal Waiting Room program in the ED.		Explore (review of research and leading practices, environmental scans), design and test (pilot on one unit using PDSA cycles) the concept of a horizontal waiting room and develop action plans to address them.	# of pts offloaded to horizontal waiting room Physician Initial Assessment for EMS patients AOT for horizontal WR patients	PIA: Under 3 hours AOT for HWR: Less than 90mins		Implemented	Improved but not met	Implemented at all sites with continued efforts to make improvements.					
														Update Charge Nurse standard work and orientation with a focus on how to enhance flow in the ED.		Creation of a standard work document for ED Charge Nurses. Development of a robust orientation process over multiple days that includes an introduction to our PayeResults metrics and strategies to create flow within the department.	# of charge nurses trained	100% of Charge Nurses trained on new standard work approach		Implemented	Met target	Implemented at all sites.					
Equitable	Equity - Equitable	Percentage of the Niagara Health Team (Staff and physicians) who have completed relevant equity, diversity, inclusion and anti-racism education.	O = Optional	Niagara Health Team Members	Local data collection		Apr/25 to Mar/26 80.8%	85% Year-End Target based on 21.3% incremental target each quarter	We priority to ensure a high percentage of the Niagara Health Team have received this training. 85% is the goal to compensate for those who may not complete the training, due to leaves, part-time,	No	Yes	No	Patient partners on DEI Committee, community agency tables discussions, discussions with community agencies at NH DEI and Equity conference	Monthly audits of data and the sharing of the completion rates.		Audit data will be provided to unit managers to support their individualized plans to support staff in completing the training. Other strategies that will be used to support completion include YouTube video option for group viewing, DEI video series link to this module which provides a certificate upon completion and highlighting the importance of completing this training during Celebrate Diversity Month	Completion rates updated monthly.	Compliance rate at end of year 85% or greater across NH and including physicians		Implemented	Met target	The monthly audit data was helpful to leaders in increasing compliance, so was the Youtube video for groups of team members who don't have regular access to computers.	Youtube video viewing of module for departments with limited access to computers.	Implemented		Met target	The Youtube video for groups of team members who don't have regular access to computers.	This monthly audit data was helpful to leaders in increasing compliance, so was the Youtube video for groups of team members who don't have regular access to computers.
Equitable	Equity - Equitable	Rate of emergency department (ED) Re-Injured visits for individuals with sickle cell disease . Denominator: total number of people in Ontario with sickle cell disease who visited the emergency department Numerator: number of people in the denominator who had a repeat unscheduled emergency department visit for sickle cell disease within 30 days.	O = Optional				Jan/25 to Dec/25 15%	10%	This indicator was chosen as it is a provincial priority and will be part of the NH Equity Plan. An approximate reduction of 50% is the target.	Yes	No	No		To understand root causes of repeat visits and support the development of care pathways for individuals with SCD.		Conduct a root cause analysis on reasons for repeat visits for SCD patients. Subsequently, quality initiatives will be developed and implemented in collaboration with NH and community partners.	# of repeat visits for pts with SCD # of SCD pts with community care plans	10% reduction in repeated visits for patients with SCD		In Progress	Improved but not met	Waiting for HIS functions to flag sickle cell patients and monitor compliance with community care plans.					
Patient-centred	Experience Patient-centred	Did patients feel they received adequate information about their health and their care at discharge? 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?	O = Optional	Discharged Patients	Patient Survey		Jan/25 to Dec/25 51.8%	60%	An approximate 5% increase.	Yes	Yes	No	N/A	Expansion of the patient experience rounding initiative to gain patient's perceptions on the information they are provided with at discharge.		Expand the current patient experience rounding process to include a targeted approach to meet with patients who are ready for discharge with a target to engage with 4 units in 2025-26 as a pilot process. The goal is to ensure patients feel that they have received information they require before they go home and if gaps are identified they are addressed in real-time.	# of patients rounded on during PX rounding at discharge initiative on 6 pilot units. # of concerns brought forward during PX rounding about discharge that are addressed in real time	10-15 patients rounded on per month through PX rounding All patient concerns and questions about discharge addressed in real-time per month through PX rounding at discharge initiative		Implemented	Met target	All concerns at discharge brought forward during rounding, addressed in real time. Met monthly target of rounding with 10-15 patients per month, addressing X complaints related to discharge Due to nature of rounding, PE team, did not round at time of discharge, so asking the question posed a challenge HIS implementation impacted familiarity with discharge instructions sheet being consistently provided to patients and families	ED/ Working Group established Discharge Planners asking patients/families, if they feel they have adequate information prior to discharge QR codes to increase email collection from patients to complete survey			Unclear/Not Available	This change idea has just begun.	
														Inpatient Discharge Information Process		Pilot a program or 3-3 inpatient units in which the Patient Experience Team in partnership with primary nurses will directly ask patients being discharged if they have the information they need if they become worried about their condition or treatment after they leave the hospital	# of patients engaged in discussion about receiving the information they need prior to discharge	80% of patients on the pilot units are engaged in discussions about receiving the information they need prior to discharge		In Progress	Improved but not met	Started in Q4, and unable to get a clear understanding of impact, and outcomes. Modified approached, and managers using huddles to engage nurses in asking questions directly related to adequate information on discharge This approach/strategy will continue into the 2026/27 QIP						
Safe	Safety Effective	Rate of In-Hospital Delirium per 1,000 Acute Care Discharges 65 years of age and older. In-hospital delirium rate is calculated by dividing the number of discharges for patients 65 years and older with an in-hospital delirium event by the total number of discharges for patients 65 years within the same timeframe.	O = Optional	Discharged Patients			Jan/25 to Dec/25 26.8 per 1000	100 per 1000	*The rate is higher (100) to ensure we are identifying individuals with Delirium based on research that outlines a minimum of 10% prevalence for hospitalized older adults.	No	No	No		Development of a robust initiative screening, identification, and diagnosis of In-Hospital Delirium as part of the DAM provincially supported initiative.		Optimization of hospital information system to prompt CAM tool completion and support the notification to MRP for positive screen of delirium. Review, revise and implement educration for staff on adult inpatient units regarding In-Hospital Delirium, use of the CAM screening tool for identification and subsequent diagnosis. Development and implementation of education on delirium prevention strategies for staff, patients, and families in emergency departments (ED).	% CAM tool completion % adult inpatient units provided with education sessions and huddles focused talks related to Delirium % of applicable patients and families indicating awareness of delirium prevention strategies while in the ED	80% increase in CAM tool completion from baseline performance 100% of adult inpatient units have had education sessions and huddles 50% of applicable patients and families in the ED are aware of delirium prevention strategies.		In Progress	Improved but not met	Results of Process Measures: Through a QI initiative on two acute inpatient units, there was a sustained increase in CAM tool completion from 4% and 3% to 32% and 76%, respectively. 100% of adult inpatient units were provided with education sessions and huddles focused talks related to Delirium. Through a point-in-time audit in one emergency department, 73% of applicable patients and families indicated awareness of delirium prevention strategies while in the ED. Successes, Challenges, Barriers, and Enablers: A key enabler of our work is our highly engaged team and the fact that delirium is on our Care for Older Persons Strategy, which is an organizational priority. A success of our work has been increased awareness of delirium amongst staff, patients, and families. One way we did this was by rounding at all sites with our Patient Partner to share	Launch the CAM tool in one emergency department	Implemented		Improved but not met	Results of Process Measures: The CAM tool completion was 47% in the first month after launching and was sustained at 63% in the months that followed.	