

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

April 1, 2026

OVERVIEW

Niagara Health's 2025/2026 Quality Improvement Plan (QIP) reflects our quality and safety commitments to our patients, families and the community as we work towards implementing our 2023-2028 Strategic Plan Transforming Care. A central pillar of our Strategic Plan is Safe and Quality Care and the QIP serves as a complement to the strategic plan, our operational plans, and our Hospital Service Accountability Agreement. As a community-based academic hospital and learning organization, our focus on teaching and learning, research, innovation and partnership propel us to continually improve care and make a difference in people's lives.

Our areas of focus to drive Quality and Safety improvements are centered on:

- Ensuring Patient Safety Culture: Balance accountability with fairness and focusing on the system rather than individual blame.
- Build Capacity: Develop the skills and knowledge to engage in quality improvement activities and enhance ownership of quality and patient safety at all levels of the organization.
- Embed sustainable improvement: Lead the development, implementation, sustainability and spread of quality improvement initiatives to support strategic priorities.
- Leverage regulatory requirements: Use Accreditation, the QIP and publicly reported performance indicators as meaningful requirements to drive change.

In late 2024, Niagara Health (NH) implemented a new Health Information System (HIS), a significant technology investment focused on improving quality and safety. With clear, accurate information at their fingertips, healthcare providers can reduce the

risk of errors, enhancing patient safety and reliability in treatment. Knowledge is power, and the new HIS leverages data to inform clinical direction and safety. Our unrelenting focus over the next year will continue to be on quality and safety through Accreditation and operational readiness planning for the opening of our new South Niagara Site in 2028, culminating in a three-site hospital system for the region.

QIP Areas of Focus for 2025/26

NH's QIP is one mechanism to chart our progress towards creating a positive patient experience and delivering high-quality, safe health care. The initiatives in this QIP focus on:

- Reducing ambulance offload delay across all sites: Our goal is to harness the successes made at the Marotta Family Hospital and spread this work to all sites across NH through thoughtful scale and spread frameworks.
- Ensuring that patients receive hip surgery within 48 hours: Our goal is to meet the provincial target for patients requiring hip surgery.
- Continued focus on staff training in diversity, equity, inclusion (DEI) and anti-racism: Our goal is to continue to demonstrate our commitment to DEI through engaging our staff in focused training each year.
- Improving physician assessment times for individuals with sickle cell disease: Our health equity goal is to ensure that individuals with sickle cell disease are prioritized for care appropriately.
- Providing essential information at discharge to support our patients: Our patient experience goal is to ensure our patients understand their next steps in their care journey when they leave

our hospitals.

The narrative that follows highlights a number of initiatives underway across NH to continue to strengthen our performance as it relates to access and flow, patient and provider experience, health equity and Indigenous health commitments and continued focus on building a culture of quality improvement and safety.



ACCESS AND FLOW

Access to care and optimizing flow through NH is our priority. One of the most pressing issues we face today is hospital capacity. Many inpatient beds are occupied by patients who no longer need hospital-level care. This creates a ripple effect — emergency departments back up and patients waiting for an inpatient bed spend longer times being cared for in emergency departments.

That's why our laser focus on patient flow — ensuring people are cared for in the right place — is essential. When patients can safely recover at home or receive care in the community, it frees up beds for those who truly need them and leads to better outcomes, especially for older adults. Programs like Niagara Health at Home are helping. More than 430 patients have transitioned safely home after hospital or avoided admission altogether. With the right support, people recover better and faster outside hospital walls.

We also know our wait times, especially in emergency departments and diagnostic imaging, are still too long. We've expanded support roles and introduced initiatives like the ED Ambassador program to improve safety and communication in waiting rooms. We've also added new Nurse Practitioners to our emergency departments to enable faster access to care for patients waiting. Our partnership with local physicians through SCOPE Niagara (access to virtual specialist consultations) has also successfully prevented unnecessary emergency visits.

Niagara's increasingly aging population with complex care needs and the region's high rates of chronic conditions coupled with challenges in access primary care is further compounding pressures related to access and flow.

That said, we are working collaboratively with our partners at Ontario Health West, and in keeping with our Home First Philosophy, we have developed collaborative action plans with our community partners. Across the province there are more than 5,000 people with an Alternate Level of Care (ALC) designation waiting in hospital beds, with approximately 46% waiting for LTC. Fifty percent of older adults experience functional decline and

increased dependency during prolonged hospitalization. To optimize patient outcomes and system capacity it is imperative that we shift away from an "LTC-first" approach. Aligned with the ALC Leading Practices guidelines and senior friendly principles, we are focused on the following initiatives:

- Hospital to Home program model: As a strategy to reduce ALC days, ED visits and hospital readmissions, the program offers two streams to provide wrap around services that support transition from hospital to home.
- Expansion of the LEGHO (Lets go home) program: A partnership with Community Support Services Niagara, which supports admission avoidance and provision of additional supports at home including meal delivery, transportation to follow-up appointments, homemaking and wellness checks.
- Implementation of Dementia Resource Pilot: A partnership with the Alzheimer's Society of Niagara in all our EDs, which supports admission avoidance by providing access to outreach and home support options.
- Collaborative Community Partner Meetings: Regular meetings with our community partners (e.g., Hospice Niagara) to identify opportunities to support patients at home based on their needs.
- Regular access and flow steering committee meetings: Meetings including partners such as Hotel Dieu Shaver as well as Patient Partners, with a prime focus on ensuring patients are cared for in the right bed, at the right time, in the right care setting, based on their clinical needs.
- Individuals who are Unhoused: A Niagara Health/Niagara Region partnership focused on understanding current state and developing solutions to support the unhoused population.
- External Emergency Department Consultant: An external review

was completed in early January 2026 with priority projects currently in development.

- **Flow and Access Consultant Report:** An external consultant has recently completed an access and flow analysis at Niagara Health and multiple initiatives are underway to support improved performance and flow optimization.

EQUITY AND INDIGENOUS HEALTH

At Niagara Health, we remain dedicated to advancing Indigenous cultural safety and health equity through education, community engagement, front line support services and policies and procedures. Our approach aligns with provincial priorities and Service Accountability Agreement obligations, ensuring our efforts are comprehensive, measurable, and embedded within organizational planning and clinical practice.

Building on foundational work completed in 2024/25, our inaugural 2025–2028 Health Equity Plan and the Indigenous Health Services Plan Journey to Reconciliation centres on advancing targeted strategies to address systemic barriers, improve equitable access, patient experience, and enhance health outcomes for our priority populations. These plans integrate provincial direction and are supported by strengthened governance structures and defined leadership accountabilities.

Notable examples of our work in these areas include:

- **Dedicated Indigenous Health Services and Reconciliation team:** Offering cultural support, advocacy, and health system navigation tailored to the needs of Indigenous patients and families
- **Enhanced Partnerships:** Strengthening partnerships with

provincial and local Indigenous organizations to improve access to culturally responsive care when Indigenous patients present at the ED or outpatient clinics.

- **Mandatory Indigenous Cultural Safety Training:** Training for all staff and provided to physicians, learners, and volunteers.
- **Mandatory Health Equity and DEI Essentials Training:** Integrated training provided at new employee onboarding and through clinical education days.
- **Data Collection Strategy:** Phase 1 implementation of a standardized sociodemographic data collection strategy, beginning with Indigenous identity.
- **Standardization of Care Pathways for Patients with Sickle Cell Disease:** Advancement of standardized care pathways and best practice alignment for patients with sickle cell disease, addressing known disparities in emergency care and pain management.

PATIENT/CLIENT/RESIDENT EXPERIENCE

During 2025/26, we continued to advance our Reimagining Patient Experience Plan 2025-2028, co-designed by patients, caregivers, staff, physicians, volunteers, and the community. We will advance our strategic priorities in patient experience to ensure our Six Key Elements (See Graphic Below) are translated into day-to-day care practices. Following release of the plan in April 2025, organizational efforts have focused on reinforcing the shared definition of patient experience and the Six Key Elements of Patient Experience across clinical programs, with an emphasis on using patient feedback to guide improvement priorities.

We continue to use patient experience data to identify areas of variation and inform focused quality improvement efforts. Real-time and post-discharge survey results, alongside feedback

gathered through patient experience rounding and direct bedside conversations, are reviewed to identify recurring themes and opportunities for improvement. These insights are shared with operational leaders and front-line teams to support targeted improvement actions.

A particular area of focus has been on ensuring patients receive adequate information on discharge. To address this, we have strengthened the collaboration between the Office of Patient Experience and the Access and Flow team to integrate a standardized question into discharge planning processes. This enables consistent, patient-centred conversations and supports earlier identification of information gaps that can be addressed before discharge. To support sustained improvement in our discharge processes, an organizational Discharge Working Group was established to review discharge-related patient experience data, monitor trends and identify improvement opportunities which includes leveraging our Health Information System.

Patient partnership continues to support this work by ensuring that improvement efforts remain grounded in patient and caregiver perspectives. Patient Partners are engaged in quality improvement projects, including the development of the QIP and discharge-focused improvement initiatives. Through their participation, Patient Partners share lived experiences, identify gaps in current processes and provide feedback on proposed change ideas. This ensures improvement priorities and strategies reflect patient-identified needs and preferences.



PROVIDER EXPERIENCE

At NH, our People Plan: People First is the foundation of our commitment to fostering a thriving hospital community. Aligned with our Strategic Plan, this plan guides intentional investments to support our people, ensuring a culture that prioritizes patients, inclusion, safety, collaboration, and the tools necessary for success. The People First plan focuses on three key areas and associated actions:

- **Growing a Qualified and Capable Talent Pipeline:** To attract, develop and retain top talent, we engage in provincial strategies such as the Community Commitment Program for Nurses, Nursing Graduate Guarantee, and the Supervised Experience Partnership. has been recognized as an Employer of Choice (8 years) and Best Diversity Employer (4 years). We have also launched an external

recruitment campaign [Make Niagara Health Your Home] and support developing our people through programs such as Bursary, LinkedIn Learning, Leadership Niagara, Extraordinary U, Building Bridges mentorship program, and programs to support our internationally educated team members.

- **Creating an Environment Where Teams Are Healthy and Well:** Employee well-being is central to our mission. We provide support through Be Well, Occupational Health and Safety, and Injury Prevention Teams. Dedicated wellness spaces, social worker support for staff and physicians, the Employee and Family Assistance Program, and peer-to-peer wellness programs contribute to a healthy workplace. Additional initiatives, such as Code Lavender, critical incident debriefing and workplace violence prevention, reinforce our commitment to safety and well-being. We have also launched a breast screening program: drop-in breast screening program for all team members and have equipped our leaders with the attendance dashboard to provide leaders with accurate and timely attendance data to inform staff outreach and team support to stabilize workforce scheduling.
- **Building and Sustaining an Environment of Respect:** We foster a culture of kindness, inclusion and mutual respect. Our Diversity Equity and Inclusion Action Plan, mentorship and bursary programs for equity-deserving team members, and Indigenous Health Services initiatives promote diversity and reconciliation. Mandatory training on cultural humility, anti-racism and respectful workplaces, along with workplace remediation programs and our Acts of Kindness challenge, help ensure a safe and inclusive environment for all. Research demonstrates the correlation between organizational culture and patient experience and by putting our people first, we can contribute to better patient outcomes strengthening Niagara Health as a place where everyone can thrive.

SAFETY

Our Integrated Quality Management Framework is embedded in a deeply held belief in the importance of creating a culture of patient safety. Through the lens of James Reason’s five subcultures of informed, just, reporting, learning and flexible, our improvement work embraces these characteristics to provide safe care for our patients. Examples of these attributes can be seen in the way we strategically invest in our incident reporting system which facilitates reporting of incidents from near misses to critical events (reporting culture) which then triggers a review of the incidents in a fair and just approach through our non-punitive Quality of Care Reflective Review processes (just culture). We systematically track and review our incident trends which form the basis for our quality improvement initiatives that drive both unit level and organization wide improvements (learning culture).

By providing data reports to directors and managers linking patient safety improvement efforts to operational activities, we are committed to “closing the loop” to help staff understand the risks in the environment and identify mitigation strategies (informed culture). From an accountability lens, patient safety data is reported through program level meetings to ensure directors, heads of service, chiefs and managers are aware of the patient safety trends that impact their respective areas. There is also a line of sight to these risks for the Board through the Quality and Patient Experience Committee of the Board and through an enterprise Risk Register monitored by the Board of Directors. The collective responsibility for patient safety is seen at all levels of the organization, which helps to prioritize patient safety in everyday activities and develop innovative real time solutions (flexible culture).

As part of our commitment to minimizing the risk of the occurrence of never events, we conduct quality of care reviews on never events to understand system-level contributing factors. We have engaged in the province wide initiative for bi-annual reporting to Ontario Health to support trending and evidence-based action for never events. In particular, pressure injuries are a never event that Niagara Health has committed increased resources and effort to reduce negative health outcomes for patients. Our Pressure Injury Steering Committee is overseeing Point Prevalence studies to identify pressure injuries in real time. We have developed a new pressure injury incident review process that has helped us to understand and develop plans to address emerging trends. These targeted and strategic organization-wide initiatives highlight the importance of taking a learning approach to foster system-wide improvements.

Further examples of strategies that we continue to implement to enhance patient safety include:

- **Quality, Patient Safety and Risk (QPSR) Rounds:** To support our learning culture, three successful QPSR Rounds have taken place. One session focused on highlighting the perspectives of a caregiver using the six Patient Experience elements and physician surrounding the care of a family member to identify experience and system level improvements.
- **Refreshed Falls Prevention Strategy:** Working collaborative with the Quality and Interprofessional Practice Team, a refresh of our approach to reviewing falls, together with the way data is tracked and reported has supported the development and implementation of a new falls prevention strategy that is evidence informed.

- **Sepsis Steering Committee:** This committee supports the development and implementation of evidence informed strategies to make improvements to the identification and care interventions to reduce incidents of sepsis. Core to this work is a sepsis surveillance program, identifying opportunities to optimize the Hospital Information System through alerts, reducing catheter associated urinary traction infections and an oral care improvement project.
- **Quality Improvement (QI) Academy:** Introduction of the QI Academy, to support the development of QI knowledge and skills. This is done through a guidance/coaching framework to support the application of skills in practice through unit or program-based projects such as flagging critical results, sedation vacation in the ICU, confusion assessment screening.

PALLIATIVE CARE

The Palliative Care program provides support to patients and their families across all hospital sites. This regional program offers both inpatient and outpatient care. The team of providers includes palliative trained physicians, nurse practitioners, and registered nurses. The goal is to connect our patients early in their care trajectory to ensure that they feel informed and supported throughout their journey. The program provides coaching and training to front-line teams so that they can identify patients' needs early and manage their care effectively. There is also a focus on integrated care which enhances discharges and allows patients the opportunity to be cared for in the community.

The palliative program aligns with the work plan established by Ontario Health, the Niagara Ontario Health Team – Equipe Sante Ontario Niagara (NOHT–ESON) and the West Region Palliative Care

Network. is following the Palliative Care Health Services Delivery Framework by actioning the following plans:

- Improving Indigenous people’s experience in palliative and end-of-life care by:
 - Engaging with Indigenous advisors, clients and community members, and
 - An ongoing commitment to cultural safety training to enhance understanding of Indigenous people’s care experiences and traditions.
- Advancing tools, training and models of care that promote early identification, skills in serious illness conversations, and advance care planning across all healthcare providers by:
 - Supporting training opportunities for front-line teams, palliative care providers and leadership,
 - Increasing participation in Learning Essential Approaches to Palliative Care (LEAP) courses,
 - Implementing the Clinical Coach,
 - Supporting Nurse Practitioner-led palliative care champions at the Marotta Family, Niagara Falls and Welland hospitals,
 - Supporting SCOPE for Palliative Care, and
 - Accountability to the provincial metric of no active treatment in the last 30 days of life.
- Aligning with the Palliative Care Services for Adults Receiving Care in the Hospital Setting Model of Care by:
 - Standardizing work at NH with that of other hospitals throughout the province,
 - Focusing on timely access to care, person and family-centred care, and sustainable palliative care services, and

- Optimizing the care provided by ensuring ‘the right care is provided by the right provider at the right time’.

POPULATION HEALTH MANAGEMENT

NH is a proud partner of the Niagara Ontario Health Team – Equipe Sante Ontario Niagara (NOHT-ESON). With a goal to improve population health outcomes, partners from across the continuum of care work collaboratively to understand and implement opportunities to transform the healthcare system in Niagara. Using a consensus decision-making model, over 45 partner organizations and patient/client/family/caregiver (PCFC) representatives have been working diligently to improve the way we operate as a connected system, considering all aspects of a patient’s journey, working to ensure more equitable care for those seeking care in Niagara.

Through funding made available from the NOHT-ESON, NH recently participated in a collaborative effort with Brock University, Niagara College, the Niagara Health Knowledge Institute, and Niagara Region Public Health to bring together data, research, and system expertise across Niagara. Quantitative analyses were led by Niagara Region Public Health using existing data sources. The Niagara Health Knowledge Institute (NHKI) supported the conceptual framing through a rapid review of national and international literature on health system capacity. The report *Planning for the Future: A Data Informed Health System in Niagara* establishes a baseline understanding of the region’s population health, service utilization, and available resources to guide collective planning and investment over the next five to ten years. This report will continue to inform NH’s population health approach.

In addition, NH is working in collaboration with regional partners to identify opportunities to support our unhoused residents aligned with commitments in our inaugural Health Equity Plan. Projects continue to be developed and implemented with a lens to population health such as understanding community sources of sepsis infection and the implementation of social prescribing to support isolated seniors.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

As part of our ongoing commitment to quality improvement and patient safety, we conducted an in-depth audit of 150 patient charts identified through the 72-Hour Return Visit Program. The purpose of this review was to understand drivers of early return visits and identify opportunities for improvement in care, processes, and system-level supports.

Across the completed audit, the following themes emerged:

- “Familiar Faces” – High-Utilization Patients: A considerable portion of return visits involved frequent ED users with complex chronic medical or social needs. These revisits most often reflected expected patterns of care rather than gaps in assessment, treatment, or discharge planning. At present NH has three initiatives that are aimed at supporting our Familiar Faces patients:
 - “MHART” (Mental Health and Addictions Response Team): Collaboration with Niagara Emergency Medical Services (EMS) where a mental health worker from NH works in community alongside paramedics. They visit individuals in the community to pre-emptively support them in the community so they do not attend at the ED unnecessarily.

- When a patient attends the ED who is known to Social Workers, there is an automatic referral to Social Work who provide immediate support.

- Further to the above, there is a focused effort on supporting patients who are deemed “No Medical Reason to Admit”. This approach focuses on wrap around multidisciplinary supports for patients, organizing services and resources the patient requires to return to the community, with the goal that the services they are connected to will then allow them to remain in community and avoid returning to the ED.

- Cardiac Patients Returning from Hamilton for Continued Care at NH: A consistent theme involved patients who had been transferred to Hamilton for urgent cardiac assessment or intervention but subsequently returned to Niagara Health for continued management. Due to the fact that our site does not provide emergent cardiac catheterization, patients requiring these services are appropriately transferred to a tertiary cardiac centre. Once stabilized, they are repatriated back to our hospital for ongoing care, monitoring, or completion of treatment. These return visits were appropriate, expected, and aligned with regional cardiac care pathways—not indicators of care concerns.

- Return Visits Due to Ultrasound Availability: A subset of return visits involved patients who required diagnostic ultrasound when the service was not available on site. With ultrasound accessible until the evening hours, some patients were discharged with instructions to return for scheduled imaging the following day. These revisits were driven by resource availability rather than issues in care quality.

- **Practice Issues Resolved Through HIS Forced Functions:** The audit identified a small number of return visits linked to workflow or documentation inconsistencies. These concerns have since been addressed through the implementation of forced functions within the Hospital Information System (HIS). Examples of these new HIS functions include mandatory data fields, standardized prompts, and system safeguards that prevent incomplete orders. These improvements have strengthened practice consistency and reduced modifiable risks for return visits.

EXECUTIVE COMPENSATION

NH's Executive is held accountable for the implementation of identified change ideas and achievement of targets set out in the annual QIP. This includes linking a subset of QIP indicators to performance-based compensation to drive alignment with organizational strategy and reinforce the commitment to drive quality improvement to further enhance patient and provider experience.

CONTACT INFORMATION/DESIGNATED LEAD

The contact information for the Designated Lead is Dr. Madelyn Law, Director of Quality, Patient Safety and Risk.
madelyn.law@niagarahealth.on.ca

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 **April 1, 2026**

Marylee O'Neill, Board Chair

John McKinley, Board Quality Committee Chair

Lynn Guerriero, Chief Executive Officer

Tara Coffin-Simpson, Tara, EDRVQP lead, if applicable
