2024/25 Quality Improvement Plan
"Improvement Targets and Initiatives"

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

Hospital

niagarahealth
Extraordinary Caring. Every Person. Every Time.

AIM	Measure									Change				
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**
Access and Flow - Timely	90th Percentile ambulance offload time	O	ED patients	Hospital collected Data	962	Baseline - Dec/22 Nov/23 136 minutes at the 90th percentile out of 36,841 ambulance arrivals	122 minutes at the 90th percentile, assume same 36,841 ambulance arrivals	11% improvement to 122	Niagara EMS	1) Refresh and implementation of the Fit2Sit Program in the ED	Updating Fit2Sit criteria together Clarifying Fit2Sit process and educating NH Staff & EMS Create more materials for patients & families including waiting room , digital screen posters, NH's ED & UCC Wait Times website	# of Fit2Sit patients # of NH staff & EMS paramedics educated #/types of materials created for patients and families Ambulance Offload Time (AOT) of Fit2Sit pts	(pending baseline data from DST/EMS) 100% trained 3 materials developed (posters, patient information sheets, video for waiting room) Pending baseline data - Laura to decide	This is a pre existing program that will be refreshed and implemented to support those individuals who are well enough to sit to wait to see a health professional. It is important to note that this is also a refresh of a previous created program.
										2) Process developed and implemented for EMS arrivals to be triaged immediately	Triage Nurse prioritizes EMS patients in the triage line	# of patients triaged through the new process Ambulance Offload Time for associated immediately triaged patients	Baseline data to be captured in year one	Having a process where the patients are prioritized at triage will then alleviate the EMS staff to return to the road. The goal would be to triage these patients who can then be attended to by the ED Tech/Offload Nurse or to FittoSit
										3) Offloading EMS to Offload Nurse or ED Tech	Triage Nurse will offload EMS patient to Offload Nurse or ED Tech while waiting for space in ED for patient	# of patients Offload Nurse & ED Tech attend to Ambulance Offload Time for those offloaded pts	Baseline data to be captured in year one	
										4) CPOD	Patients presenting with Mental Health & Addictions complaint are triaged and sent to CPOD, PERT Proper, or MH&A Hallway	# of patients sent to CPOD, PERT Proper, or MH&A Hallway Ambulance Offload Time for those MH&A patients # of Code Whites linked to the patients transitioned to CPOD as compared to those who were not	Baseline data to be captured in year one	This is to be done only at SCS
Equity - Equitable	Percentage of staff who have completed relevant equity, diversity, inclusion and anti-racism education	O	Niagara Health Staff Members	Local data collection	962	Baseline - Apr/22 - Dec/23 78.58% 4,412 staff completed the module out of 5,615 active staff accounts	Need 4,773 staff to complete module assuming same 5,615 active staff accounts	6.42% improvement to target 85%	N/A	1) Leadership engagement in San'yas Training	All senior leaders, directors and managers are provided with San'yasTraining through an online module training program.	# of leaders (managers, directors, supervisors, EVPs and President) completing the training	100% of all leaders complete training	San'yas training is an anti-racism Indigenous cultural safety training program.
										2) New clinical hires engagement in Cultural Humility Training and the Mutually Respectful Workplace and Diversity Training	All new nurses engage in cultural humility training at orientation and are to complete the Mutually Respectful Workplace and Diversity Training	# of new hires engaged in training	100% of new hires engaged in training	Moving forward the goal will be to evaluate behavior change as a result of the training.
										3) Existing staff prompted to complete Mutually Respectful Workplace and Diversity Training	Staff are provided with the LearnH module through the internal learning platform. Managers to follow up with staff to ensure the completion of these modules within the QIP year. Managers to support staff with time to complete the modules.	# of completed modules	85% of staff complete LearnH module	Moving forward the goal will be to evaluate behavior change as a result of the training.
Patient-centred	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	Discharged Patients	Patient Survey	962	QIP 23/24- Apr-Nov/23 49% 119 out of 242 inpatients responded 'completely'	Need 216 inpatients to answer completely assuming 415 respond to the survey (annualized projection)	3% improvement to target 52%	N/A	1) Improvements to survey methods to enhance reach of the survey.	Enhance the current process at admission to obtain patient emails to send the survey to post discharge. This will incorporate education for admission clerks on the importance and process for communicating with patients on the rationale for collecting emails. As well as considering alternative methods to reach patients {(i.e. text message with survey; gathering feedback on day of discharge before leaving the hospital). By engaging with the Patient Partners the team will identify best possible approaches for gathering feedback.	# of patient emails obtained # of educational sessions (i.e. huddles) with admission staff # of resources developed for staff (LearnH module, information sheets on how to collect this information)	30% of patients admitted provide emails	Focusing on how we obtain the data through our survey is dependent on our processes to reach our patients post discharge. Having a robust process at admission will enhance our response rate and provide robust information for improvements.
										2) Review internal processes for providing discharge information	Collaborate with professional practice (nursing) and discharge planners to review and refine discharge practices.	Creation of standardize tools and workflow processes that are tailored to programs; patient satisfaction with discharge information.	Baseline data to be captured on the patient satisfaction with processes to help inform further refines to the process. This will be captured in real time on the unit before leaving the unit.	The review and refinement of current practice will be done in collaboration across programs and in consultation with patient partners.

AIM	Measure									Change				
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**
Safety- Effective	Medication reconciliation at discharge	O	Discharged Patients	Local data collection	962	Baseline - Jan-Dec/23 80.8% annual performance 22,932 completed forms out of 28,390 patient discharges	Need to complete 24,734 forms out of an assumed 28,390 patient discharges	6.3% improvement to target 87.1% - Niagara Health continues to improve on this metric and setting this realistic and achievable goal will allow for continued progress towards higher rates of Med Rec completion.	N/A	1) Collaborative Quality and Med Rec Pharmacist Huddle	A Quality team Member together with the Med Rec Pharmacist will attend each units huddle twice in 2023-24 to discuss med rec on discharge including the process, roles, responsibilities, barriers and opportunities for improvement.	# of clinical unit huddles attended	100% of clinical huddles attended twice per QIP year	Given the number of huddles that occur at multiple sites at NH, the twice per year approach is feasible to support Med Rec messaging and discussion.
										2) Monthly physician data review	Monthly reviews of med rec will be conducted by program chiefs or delegate to identify low-performing physicians and personalize plans for improvement.	Each program to choose a target to meet every quarter	Improve physician performance on med rec by 5% each quarter	The focus is on physicians completing the Med Rec to ensure safety of patients and engrain this behavior and action to support the transition to the new HIS.
										3) Monthly completion of Quality audits	Completion of 20 Med Rec at discharge audits by the Med Rec Pharmacist per month retrospectively.	20 per month	75% meet criteria	