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

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

Hospital

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AIM		Measure												Change					
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 Audits?**	**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**
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		Dec/23 to Oct/24 NH: 116 mins SCS: 108 mins NFS: 130 mins WS: 113 mins	90 minutes	The target focuses on a step wise approach to improve towards the HNHBB benchmark of 86 minutes.	Yes	No	Yes	Niagara EMS	Scale and Spread Fit2Sit improvements to remaining 2 sites.		Identify factors to support the spread of the F2S at each site through process mapping, reviewing and sharing lessons learned from other sites and subsequently develop action plans for implementation.	% of eligible F2S patients identified and part of the program within 30 minutes of triage # of NH staff & EMS paramedics educated on the F2S program Ambulance Offload Time (AOT) of Fit2Sit pts Ambulance Offload Time (AOT) of all pts at 90th percentile	100% Niagara EMS & ED Staff educated on the F2S program 85% Eligible F2S pts are identified and part of program within 30mins of triage. 90 Minutes AOT of F2S patients	
														Explore the potential for the implementation of a Horizontal Waiting Room program in the ED.		Explore (review of research and leading practices, environmental scan), 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	
														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 Pay4Results metrics and strategies to create flow within the department.	# of charge nurses trained	100% of Charge Nurses trained on new standard work approach	
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		68.17% 3,911 staff completed the module out of 5,737 active staff accounts	85% Year-End Target based on 21.3% incremental target each quarter	NH 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, etc. who may	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	
Equitable		Rate of emergency department 30-day repeat 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				April 1 to Sept 30,2025: In order to protect patient privacy the data is suppressed.	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	
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		55.44%	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 6 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 PE rounding at discharge initiative on 6 pilot units. # of concerns brought forward during PE rounding about discharge that are addressed in real time	50-55 patients rounded on per month through PE rounding All patient concerns and questions about discharge addressed in real-time per month through PE rounding at discharge initiative	
														Inpatient Discharge Information Process		Pilot a program on 1-3 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	
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			28.76 (Q1+Q2) 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 DASH 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 education 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	30% 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	