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

February 23, 2024

This is a temporary excel work plan template for planning purposes, there is no upload function to Navigator

Navigator will be open for hospitals in mid-January after pre-population of administrative data takes place

AIM		Measure								Change				
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	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) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)														
Access and Flow	**Timely**	90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2)	34.3 hours as of December 2023 (time from admission to inpatient bed) 33.6 hr. for peer group average (2021/22)	30 hr.	Reduce the use of Emergency Department as admitted patient holding area. Annual target is set based on incremental improvements.		Improve patient satisfaction by transferring patients from the ED to an inpatient bed resulting in a decreased length of stay.	1) Revise Bed Utilization Management (UM-Util-01) policy. 2) Daily bed rounds (10:00 daily and 13:00 as needed) - forum to discuss/resolve bed flow challenges. 3) Ensure all inpatient beds including blocked beds are assigned within a timely manner by the admitting clerk. 4) Improve the 1100 hr. discharge time. 5) Share and seek guidance from Patient Flow Steering Committee for improvement opportunities.	Number of admission in the ED at 0800, 1500, 1900 hr.	% improvement for time to inpatient bed.	
Equity	**Equitable**	Percentage of staff (executive-level, management, all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	90% of Executive Level Staff within the past five years; Collecting Baseline for Managers and All Staff	100% of Executive Level Staff; 50% of Management; 15% of All Staff	100% of Executives have to complete as per our SAA; Internal SP2026 Cultural Safety Training Core Team set reasonable targets for Management and All Staff based on the capacity of our Cultural Safety Educator. Target is completion of "Repairing the Sacred Circle" as part of comprehensive, regionally specific training.	Joint Indigenous Cultural Safety and Education Committee (with St. Joseph's Care Group)	Strategic Plan 2026 has an EDI Initiative to implement Cultural Safety and other relevant EDI training within the organization	1) Staff: Cultural Safety Educator, Interprofessional Educator 2) Offer various forms of cultural safety and other relevant EDI training to all staff	1) Ensure staffing is maintained 2) Track % of staff (broken down by Executive Level, Management, and All) who have completed relevant training	Progress for process measure will be an increase in each quarter until target is reached.	
Experience	**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	% / survey responses	CIHI CPES-IC most recent	64%	Collecting baseline	CPESIC survey distribution interrupted with NRC discontinuation. Onboarding, procurement and implementation of new vendor included delays outside of control. As a result, survey distribution began June 2023 with low sample size. Other technological issues on vendor side have also caused disruptions in data collection and have significantly impacted Q3 results. Additionally benchmarking for CPESIC is not currently available and also expected to have delays.		Ensure all patients are provided and understand discharge paperwork, patient education regarding condition and are provided the appropriate tools to manage care post discharge.	1) Develop plan for staff education of standardized discharge process, as well as plan to implement standardization into workflow at bedside. 2) Extend patient resource folder trial to all units as a means to close health literacy gap, assist in retention of education for patients, increase care partner involvement and ultimately improve patient experience. 3) Maintain auditing compliance regarding discharge process (currently being conducted by Post Discharge Liaison (PDL) and Discharge Transition Lead however funding expiring (March 31, 24). 4) Educate and implement teach back communication strategy to ensure patient understanding of discharge instructions.	Patient response to Q. 38 on CPESIC, % of patients who have received written post discharge instructions (through health records audit and PDL statistics and interventions), percent of post discharge liaison intervention (suspect decrease of interventions needed if proper discharge process followed).	Increase of patients reporting the received paperwork during PDL contact, increase in health record file audit, decrease in interventions needed by PDL.	
Safety	**Effective**	Medication reconciliation at admission: Total number of admitted patients for whom a Medication Reconciliation is completed within 48 hrs of admission.	O	% completed Med Rec on Admission within 48 hrs / All admitted patients staying >48 hrs (excluding infants that are born in the hospital)	Local data collection / Most recent consecutive 12-month period	2023/24 Q3 Result = 39.76% (target for Q3 45%) Target = 57.5% by Q4	65%	Increase Best Possible Medication History (BPMH) on admission translated to completed Med Rec.	None	1) Use of New Pre-Printed Direct Order (PPDO) to ensure BPMH is converted to Med Rec Completion by MRP. 2) Increase Prescriber engagement. 3) Increase front-line staff awareness of Med Rec Completion process. 4) Determine additional resources required to improve Med Rec on admission across the organization. 5) Develop a Medication Safety Officer (MSO) job description and evidence for need with intent to lead Med Rec and ROP requirement progress.	1) Registered Pharmacy Technician (RPhT) or pharmacy student will document discrepancies on admission on new PPDO which when prescriber completes, becomes ordered medications, and completes Med Rec Process. When pharmacy receives signed PPDO, Pharmacy will complete intervention for Med Rec on Admission in PCS. 2) Provide education and engagement with prescribers on role in completing Med Rec and addressing. discrepancies including implementation of new PPDO. 3) Utilize Quality Huddles to engage nursing to identify patients with outstanding Med Rec on Admission completion -Pharmacy to speak at Quality Huddles regarding process and new PPDO 4) Pharmacy leadership to benchmark number of pharmacists and technicians with Decision Support involvement. 5) Pharmacy leadership to provide evidence and develop business case for MSO.	1) Capture completed BPMH within 48hrs (future state see blow) compared to completed Med Rec on Admission within 48 hrs. 2) Number of engagement sessions. 3) Number of quality huddles pharmacy attends to discuss med rec quality improvement processes. 4) Plan is completed and brought to Med Rec Committee, Operational Leadership Committee and Senior Leadership Committee. 5) Business case is completed and brought to Med Rec Committee, Operational Leadership Committee and Senior Leadership Committee.	1) Working with Business Intelligence Team to monitor BPMH to Med Rec Conversion. Trial on one unit to collect baseline data. 2) Target 50% of section meetings by Q4. 3) Pharmacy engages 100% of inpatient units via Quality Huddles by Q2. 4) Plan presented by end of Q1. 5) Business case presented by end of Q1.	