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

| AIM | | Measure | | | | | | | | Change | | | | |
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| 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 (ED) 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) | **34.5 hours** (average from April 1, 2024 to December 31, 2024)<br><br>31.81 hours for peer group average (2022/23) | **30 hours** | Reduce the use of ED 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) Daily bed rounds (10:00 daily and 13:00 as needed) - forum to discuss/resolve bed flow challenges.<br>2) Ensure all inpatient beds including blocked beds are assigned within a timely manner by the admitting clerk.<br>3) Improve the 1100 hr discharge time.<br>4) Share and seek guidance from Patient Flow Steering Committee for improvement opportunities. | Number of admissions in the ED at 0800, 1500, 1900 hr. | % improvement for time to inpatient bed. | |
| **Equity** | **Equitable** | % of management and staff who have completed relevant equity, diversity, inclusion and antiracism education. | O | % / Staff | Local data collection / most recent consecutive 12-month period | Managerial **51%**<br>General Staff **5%** | **75%** of Management;<br>**15%** of All Staff | Internal SP2026 Cultural Safety Training Core Team set reasonable targets for Management and All Staff based on the capacity of the Cultural Safety Educator and Elders. 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.<br>2) Offer various forms of cultural safety and other relevant EDI training to all staff. 3) Develop a plan with Human Resources to identify other funding sources to support and enable participation of frontline staff. | 1) Ensure staffing is maintained<br>2) Track % of staff (broken down by Management and All Staff) who have completed relevant training | Progress for process measure will be an increase in each quarter until target is reached. | Executive level target has been removed as 100% achieved in last QIP. |
| **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 | Q1-Q3 **69.28%** | **70%** | This target is more conservative due to the uncertainty of low sample size, the variance in sample size drastically impacts the scores (as seen through Q1-Q3 FY24/25). This improvement is an incremental but significant goal within the context of ongoing efforts to elevate patient experience. Achieving this improvement will lay the foundation for further enhancements in the discharge process and broader patient experience metrics. | OHA peer benchmarking if available | 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) Standardized Discharge Process: The discharge process will combine the Teach-Back method and person-centered communication. Staff will use Teach-Back to confirm patient understanding of discharge instructions, while personalizing the approach to meet individual needs, preferences, and health literacy levels.<br>2) Clear Discharge Paperwork: Patients will receive easy-to-understand discharge instructions through the patient resource folder, which will include condition-specific education and follow-up care details.<br>3) Post-Discharge Tools: Patients will be provided with resources through the post discharge liaison role to help manage their care after leaving the hospital.<br>4) Continuous Feedback: Patient surveys and follow-up calls will gather feedback and data to ensure the discharge process is clear, effective, and patient-centered. | 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). Additionally, Q38 has been added to ALL inpatient and ED surveys, allowing for greater sample size and internal measure of metric improvement | Increase of patients reporting the received paperwork during PDL contact, increase in health record file audit, decrease in interventions needed by PDL. | Planned improvement initiatives dependent on continued funding for specific supportive positions set to expire March 31, 2025. If funding were not continued, it would be expected that response rates would decrease. |
| **Safety** | **Effective** | Rate of 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 | 2024/25 Q2 Result = **49.40%** | **65%** | Increase Best Possible Medication History (BPMH) on admission translated to completed Med Rec.<br>Attain 65% rate of Medication Reconciliation on Admission averaged over the year FY25/26. | None | 1) Obtain baseline data on BPMH completion to determine improvement plan for Med Rec completion rates on admission.<br>2) Complete the development of an education platform for nursing staff on LMS Dual Code.<br>3) Continue Prescriber engagement to encourage use of implemented Pre-Printed Direct Order (PPDO) to support Med Rec.<br>4) Determine Additional resources required to improve Med Rec on admission across the organization.<br>5) Medication Safety Officer (MSO) to utilize audit information to make further process improvement recommendations. | 1) Work with BI team to complete data extraction of BPMH rates across units to determine baseline.<br>2) Develop LMS Dual code modules to support content delivery on Medication Reconciliation and BPMH to improve nursing staff understanding.<br>3) Increase prescriber engagement by adding PPDO refresher as an agenda item on MAC and other Divisional meetings as required.<br>4) Pharmacy leadership to benchmark number of pharmacists and technicians with Decision Support involvement.<br>5) MSO to complete and review Med Rec audit data to identify gaps in processes. | 1) Gather BPMH completion rates across units to understand baseline.<br>2) Utilize LMS Dual code to develop and deliver the content to support Nursing Staff.<br>3) Present PPDO Refresher at MAC and at Divisional meetings as requested.<br>4) Plan is completed and brought to Med Rec Committee, Operational Leadership Committee and Senior Leadership Committee.<br>5) MSO to recommend improvements based on unit audit findings. | 1) Baseline report available Q2 FY 25/26.<br>2) LMS Dual code go-live by end of Q2/Q3 FY 25/26.<br>3) MAC Presentation completed by Q2 FY 25/26.<br>4) Plan is completed and brought to Med Rec Steering Committee, OLC & SLC.<br>5) Present findings and improvement recommendations by Q4 to Med Rec Steering. | |