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

Hotel Dieu Shaver Health and Rehabilitation Centre 541 Glenridge Avenue, St. Catharines , ON, L2T4C2

AIM		Measure									Change				
Issue	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	Alternate level of care (ALC) throughput ratio excluding any patients with refugee status that are awaiting an immigration hearing	Custom	Ratio (No unit) / ALC patients	In house data collection / July 1 2024 - September 30 2024 (Q2)	790*	1.22	1.07	Current goal is very aggressive which is largely outside of HDS control and is dependent upon bed pressures throughout the Region, pressures on Ontario Health atHome, and patient's LTC choices. We also support our acute care partners during periods of surge by taking ALC patients as needed. We are currently experiencing an increase in ALC eligible patients including patients with refugee status. St. Catharines/Niagara continues to be one of the highest rate of seniors in Canada. We are above the provincial average of 0.94%. For accountability purposes, we will accept values between 0.5 and 1.07%.	Niagara Health System, Ontario Health atHome, Ontario Health West	1)Weekly ALC Rounds meetings that include Hospital Management, Case Managers, Ontario Health atHome staff/Management that review all cases that may have a challenging discharge back to their pre-hospital living arrangement.	Weekly meetings with management and staff representatives from both Ontario Health atHome and HDS to in home services available to achieve a "Home First" discharge, and exhaust all possible options before approving a patient to wait in hospital for LTC.	Regularity of the ALC Rounds meetings.	Weekly meetings to take place.	Currently we are experiencing patients that have refugee status that are awaiting immigration hearings. Despite connecting with provincial and federal government we have been unsuccessful in expediting hearing dates. Therefore, we have no control over the discharge of any of these patients destined for long term care. Any patients going to long term care must have an Ontario health card.
											2)Use of Capacity Management and Careview Boards in the new HIS to help track patients and any barriers to discharge.	Maintain current information in the HIS: barriers to discharge, estimated dates of discharge, etc. which will be viewable by all caregivers to assist with appropriate plans for patient.	Regular review of Careview Board at Patient Flow meetings held Monday to Friday.	Review of the board at least 4 times weekly.	
		Meet optimal wait times for internal inpatient to outpatient services based on stroke wait times.	Custom	Days / Stroke inpatients referred to outpatient stroke services	In house data collection / January - December 2024	790*	18.00	25.00	Hospital occupancy continues to trend upwards. Based on volumes of patients and pressures on outpatient services, and taking into account Health Human Resource challenges and Christmas shutdowns due to funding restrictions, we believe this is an aggressive target and exceptionally high standard to continue to aspire towards.	Niagara Health System, Rehab Care Alliance, Ontario Stroke Network, Patients and Families and Caregivers	1)Eliminating initial telephone screening in lieu of in-person screening by outpatient hospital staff that will result in faster access to the services.	Currently senior therapist is in-charge of all telephone screening which creates backlog. Instead rely on discharge transfer of accountability from in-patient team, set up initial visit to assess ongoing outpatient therapy needs, and book accordingly.	Monitor the new process and wait time outcomes quarterly.	Impact of monthly reviews on wait times.	
Equity	Equitable	Roll out hospital wide DEI training to all staff. ***Executive Compensation**	Custom	% / Staff	In house data collection / April 1 2025 - March 31 2026	790*	8.00	60.00	Hospital has rolled out the initial training for Managers, DEI committee and Human Resources last year with great success. We have achieved 33/41= 80% success with this group. The new target of 60% consists of all staff excluding staff on long term leaves (baseline = 431). We are mindful of the casual staff members that account for slightly over 25% of the entire workforce. Training these professionals also poses some challenges given their availability. HR will develop the all staff training and when it is rolled out, HR will track the completion rates. We will accept results between 55 and 65%.	Niagara Health System, Niagara Regional Native Center	1)Education material provided to management, DEI committee members and Human Resources(HR) staff is being reviewed and updated. All staff including management, DEI committee and HR will receive the updated training.	Collected feedback from all staff - what worked well and what could be improved.	Number of feedback surveys reviewed.	100 % of training opportunities will include staff feedback survey.	

Experience	**Patient-centred**	Percentage of complaints acknowledged to the individual who made a complaint within 3 to 5 business days ***Executive Compensation**	Custom	% / People	In house data collection / January - December 2024	790*	100.00	95.00	This is an aggressive target with additional challenges -- being the very lean staffing at the hospital and potential difficulty in staff backfill in the event of absence. However, the hospital is committed to responding to all documented complaints as quickly as possible.	Ombudsman Ontario, Politicians Constituency Offices, Patients and Caregivers	1)Enhanced publication of the contact information for the Patient Relations Process Delegate.	Ensuring notices are updated and distributed throughout the hospital, included in the Patient and Family Handbook, on the hospital website, and via ensuring staff are aware of the process.	Completion and maintenance of updated information in all areas noted above.	Bi-annual checks done at the time of the regular scheduled update to the Patient and Family Handbook to ensure all information is maintained.	
											2)Tracking of all formally documented complaints to include time of receipt to time of initial response.	Patient Relations Process Delegate to document all formal complaints with chronology for time of first response, substance of complaint, nature of resolution and resolution timelines.	Results reported quarterly to the Quality Committee of the Board, and various hospital standing committees and the Senior Team.	100% of formal complaints to be tracked and responded to in a timely manner.	
		Survey 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?	Custom	% / Survey respondents	In-house survey / January - December 2024	790*	98.23	95.00	This is an aggressive target particularly in light of the provincial average of 59% and the HNHBB average of 59%, and continuing stresses associated with viral outbreaks and HHR pressures. Therefore, for accountability purposes, we will accept results between 85-100%.		1)Continuation of surveys to be conducted with patient (or family member) three or fewer days before anticipated discharge date.	Patient Advisors provided with list of upcoming discharges and will attend at the bedside with the survey materials.	Monthly tracking of the number of discharges and the number of surveys conducted.	100% of patients with pre-scheduled discharge dates to be surveyed.	
											2)Continuous communication between Patient Advisors and Clinical Managers to ensure that any concerns are identified and flagged, and addressed prior to discharge.	Patient Relations Process Delegate ensures that Patient Advisors are aware of process to follow when patient has concerns about upcoming discharge information.	All surveys are reviewed for concern(s). The Patient Relations Process Delegate is notified and then contact is made with the Clinical Manager to address the concern.	100% of concerns regarding discharge will be reviewed (and ideally resolved) with patient prior to the discharge.	
		Patient experience: Would you recommend inpatient care to your friends and family? ***Executive Compensation**	Custom	% / Survey respondents	In-house survey / January - December 2024	790*	99.86	95.00	This is an aggressive sustainability target particularly in light of our high current performance, the HNHBB rate of 56% and the Ontario rate of 63% and the current climate of continuing outbreaks and Health Human Resources pressures. As a result, we will accept performance between 85-95%.		1)Results of patient experience surveys shared with staff on each of the inpatient units.	Patient Advisors submit their completed patient experience surveys daily, which are input into a database and results are reported back to staff at the end of each month.	Results presented include numerical information, graphs/charts as well as additional comments received from patients.	100% of all results are presented back to staff.	Unit staff appreciates hearing the results both positive, and opportunities for improvement as they want to provide high quality care for their patients.
Safety	**Safe**	Number of workplace violence incidents reported by hospital workers as defined by Occupational Health and Safety Act.	Custom	Count / Staff	In house data collection / January - December 2024	790*	61.00	60.00	We are seeing an improvement in the reporting culture post new HIS go live. This indicator assists in continuing to encourage staff to report all incidents of violence while we recognize that we can not control the type of patients being admitted. For accountability purposes we will accept results from 40 and above.	Ministry of Labour, Ministry of Health, Patients, Families and Caregivers	1)Update staff orientation packages to emphasize the importance and hospital expectations regarding reporting workplace violence incidents.	Sr. Coordinator of Safety and Abilities Management will update orientation packages. This year all staff will be retrained on workplace violence reporting.	Orientation and Training completion rates.	Monitor staff training throughout year 2025-26.	Collaborative approach with all involved.