

2026/27 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 2025 - September 30 2025 (Q2)	790*	0.92	1.02	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 at Home (OHaH), patient's LTC choices, and financial resources of patient for alternate discharge settings. We also support our acute care partners during periods of surge by taking ALC patients as needed. We continue to look for an appropriate placement for a patient with refugee status. St. Catharines/Niagara continues to have one of the highest rates of seniors in Canada. Our Q2 performance was below the provincial average of 0.98, however, there is significant variance from quarter to quarter. As an example, our Q1 performance was 1.55 and well above the provincial average. For accountability purposes, we will accept values between 0.75 and 1.25.	Medavie Blue Cross, Ontario Health at Home, Ontario Health West, Niagara Health System	1)Continue weekly ALC rounds meetings that include hospital management, case managers, and Ontario Health at Home staff/ management that review all the cases that may have a challenging discharge back to their pre-hospital living arrangement.	Weekly meetings in hopes of achieving home first discharge.	Regularity of the ALC rounds meetings.	Weekly meetings to take place.	We continue to work on trying to find a safe discharge destinations that include use of Home First process with Ontario Health at Home (OHaH), Transitional Care Beds when appropriate, as well as Heavy Care Retirement Homes, if affordable for the patient.	
											2)Working on partnership for non-traditional placement of patients with refugee status.	HDS patient flow team will continue to expand non-traditional discharge locations for patients with refugee status who do not yet have OHIP coverage. Working with a number of care providers that are registered with Medavie Blue Cross and supporting enrollment of interested care providers.	Number of refugee patients / successful placements in non-traditional discharge locations.	100% patients with refugee status will be reviewed for non-traditional discharge locations.	We feel this will be an important endeavor to support the increase in patients with refugee status that require post acute hospital care.	
Equity	Equitable	Hospital wide DEI training to all staff. *Executive Compensation	Custom	% / Staff	In house data collection / January - December 2025	790*	76.40	80	Initial training for Managers, the DEI committee, and Human Resources was rolled out in 2024 with great success. After discussion of successes and challenges, the new target of 80% is for training of all staff, excluding staff on long term leaves (baseline = 445). We are mindful of the casual staff members that account for slightly under 25% of the entire workforce. Training these professionals poses specific challenges given their availability. HR will continue to roll out the DEI training and will accept results between 75 and 85%.	Regional Native Center, Niagara Health System	1)Diversity, equity and inclusivity (DEI) information/policy to be presented during onboarding of new staff.	Human Resource (HR) Dept. has included DEI training and review of policies in the new hire orientation program. This includes students and hospital volunteers. HR leader/delegate will track the progress.	Number of DEI presentations completed over number of new hire orientations.	Percentage completion rate.	New hire orientation schedule may vary depending on number of hires per month. However, all new hires will undergo DEI training during the reporting year.	
											2)Ensure DEI training is available for staff returning from long term leaves (extended illness, parental leave, or other).	Staff that return to work from long term leaves are required to have the new Health Information Systems (HIS) refresher training, and DEI training is built into the same training session.	Number of refresher training sessions offered / number of staff returning from long term leaves.	100%.	Refresher training sessions are tentatively scheduled every two weeks to ensure returning staff have timely training. Plan will expand to capture casual staff who require training.	
		Staff in management role who have completed Indigenous Cultural Safety (ICS) Training	Custom	Count / Staff	In house data collection / January - December 2026	790*	Collecting baseline	Collecting baseline	Beginning in 2026, we aim to have 4 management staff complete the Indigenous Cultural Safety (ICS) training. To account for operational needs, preparation for accreditation, and the capital build, we will accept a range of 3 to 5 management staff being trained.	San'yas Ontario, Regional Native Center, Niagara Health System	1)This is a new indicator. The plan is for a gradual rollout to all management staff. We have a small group of management staff and courses are offered twice a year. Offering to a maximum of four management staff per year will help operations and cost effectiveness.	Human Resources (HR) Dept. will offer out the training to four management staff each year and track progress.	Number of trainings offered to number of trainings completed.	At a minimum 75% training completion.	Collecting baseline and we consider the number of training spots offered should be attainable.	

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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 2025	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 and a additional management staff delegate is assigned to cover for the patient relations lead.		1)Enhanced publication of the contact information for the Patient Relations Process Delegate. 2)Tracking of all formally documented complaints to include time of receipt to time of initial response.	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. 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.	Completion and maintenance of updated information in all areas noted above. Results reported quarterly to the Quality Committee of the Board, and various hospital standing committees and the Senior Team.	Bi-annual checks done at the time of the regular scheduled update to the Patient and Family Handbook to ensure all information is maintained. 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 2025	790*	99.19	95.00	This is an aggressive sustainability target. Work continues with the new HIS to develop additional sources of information for patients being discharged. 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. 2)Continuous communication between Patient Advisors and Clinical Managers to ensure that any concerns are identified and flagged, and addressed prior to discharge.	Patient Advisors provided with list of upcoming discharges and will attend at the bedside with the survey materials. Patient Relations Process Delegate ensures that Patient Advisors are aware of process to follow when patient has concerns about upcoming discharge information.	Monthly tracking of the number of discharges and the number of surveys conducted. 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 patients with pre-scheduled discharge dates to be surveyed. 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 2025	790*	98.39	95.00	This is an aggressive sustainability target particularly in light of our high current performance, current climate of continuing outbreaks, and Health Human Resources pressures. As a result, we will accept performance between 85-100%.		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.	

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Safety	Safe	Percentage of inpatients admitted with a pressure injury who show improvement in pressure injuries by discharge.	Custom	% / Inpatients admitted with a pressure injury, excluding End of Life patients	In house data collection / April - December 2026	790*	Collecting baseline	Collecting baseline	HDS clinical teams have observed a good success with the Wound Care team preventing pressure injuries from occurring post admission of patients. We hope to achieve similar success with maintaining/improving any level of pressure injury that is present on in-patient admission to HDS. This indicator aligns with hospital best practices of handling "Never Events".	Niagara Health System	1)Wound care champion education.	All charge nurses will be educated by wound care team led by Nurse Practitioner.	Number of charge nurses trained.	100%.	Standardized wound care documentation is already implemented with the launch of new HIS.	
											2)Use of shared resource spreadsheet to track patients.	Ward clerks will add relevant admitted patient information to the shared resource, Health Records staff will be auditing for relevant information upon discharge.	Regular review of spreadsheet to ensure all eligible patients have been tracked.	100%.		
		Percentage of reported inpatient violence incidents toward hospital workers (as defined by Occupational Health and Safety Act) that have an inpatient behavioural workplan developed.	Custom	% / Inpatient violence incidents toward hospital workers	In house data collection / January - December 2026	790*	Collecting baseline	Collecting baseline	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.	Accreditation Canada, Ontario Ministry of Labour, Niagara Health System	1)Interprofessional plan of care (IPOC) documentation in Oracle Health Information system specifically for responsive behaviours.	Nursing clinical manager in collaboration with ICT will develop the IPOC. Nursing staff will use the new IPOCs to input data that will allow clinical managers and applicable support staff to review data on care plan completion.	Percentage- Number of care plans completed /Number of violent incidents submitted.	50% care plans are developed following inpatient violent incident.	Nurses are encouraged to utilize the responsive behaviour IPOC tool in new HIS, however, any method of documentation so long as triggers, behaviours and care approach are identified.	
											2)Update workplace violence electronic incident reporting(IRS) form to improve data collection. New question in the manager follow up confirming that a care plan has been developed following an inpatient violent incident.	IRS system administrators are currently in the process of updating the forms.	Percentage completion by (April 30, 2026).	100% completion.		
											3)Instruction and training for updated IRS forms and IPOC.	Management staff will receive instructions for appropriate follow up on each violent incident and confirming a care plan has been developed. Frontline staff will receive instructions on IPOCs and IRS forms as well. HDS IRS systems administrators will conduct regular audits for care plan completions.	number of staff trained/total clinical nursing staff.	100% of nursing staff will receive instruction.		