St. Joseph's Hospital

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

St. Joseph's Care Group 35 North Algoma Street Box 3251, Thunder Bay , ON, P7B5G7

AIM		Measure								Change			
Issue	Quality dimension	Measure/Indicator	Type	Unit / Population	Source / Period	Organization Id	Current performance	Target	Target justification	Planned improvement initiatives (Change Ideas)	Methods	Process measures	Target for process measure
Access and Flow	Timely	Mental Health (Inpatient) - Active Length of Stay (excluding ALC days)	Custom	Days / Mental Health, Inpatient	Local data collection / April 2025 to March 2026	Hospital	77	73.00	5% improvement on current performance	1)Initiate discharge planning discussion at intake interview at time of referral.	PSR Coordinator to include discharge planning at intake interview.	Monthly review by Manager and Clinical team indicates discharge planning reviewed at intake interviews.	Reduce LOS median from 77 to 73 by March 31, 2026
										2)Discuss discharge planning with each new client during the Client Wellness plan within 4 weeks of admission.	Manager includes discharge planning in Client Wellness plan.	Monthly review by Manager and Clinical Team indicates discharge planning is discussed during the client wellness plan.	Reduce LOS median from 77 to 73 by March 31, 2026
										3)Promptly identify and designate ALC clients	Manager/clinical team reviews client status monthly to identify ALC status of clients, including time interval from when client is recommended for ALC to when they are designated ALC.	Time interval from when a client is recommended for ALC to when they are designated ALC is monitored.	Reduce LOS median from 77 to 73 by March 31, 2026
		Rehab Care (Inpatient) - Active Length of Stay (excluding ALC days)	Custom	Days / Rehab Care, Inpatient (2nd Floor)	Local data collection / April 2025 to March 2026	Hospital	43	41.00	5% improvement on current performance	1)Develop structured feedback loop process with referring partners for referrals and admissions that do not meet appropriate program criteria.	Clinical team will review all referred clients at daily client flow (M-F) meetings / STRATA review / Meditech review, and any identified inappropriate referrals/admissions will be brought to Joint Client Flow Meetings weekly/monthly for follow-up.	Referring partners are provided feedback when clients who are referred/admitted do not meet appropriate program criteria.	Reduce LOS median from 43 to 41 by March 31, 2026
										2)Initiate discharge planning in collaboration with client/family and interdisciplinary team within 72 hours of admission	a) Discuss discharge planning in initial client assessment, determining expected length of stay (ELOS), within 72 hours of admission. b) Document ELOS/discharge plan, and update weekly, in Meditech and on client Whiteboard c) Managers remind staff at daily escalation huddles.	Weekly review of client whiteboards and EMR identify ELOS/discharge planning information.	Reduce LOS median from 43 to 41 by March 31, 2026
										3)Request client feedback on "What support or resources would you and your family need to help manage your care and treatment after leaving the hospital?"	Manager adds question to initial client assessment and discharge planning meetings checklist.	Weekly review of updated checklist identifies question has been asked to client.	Reduce LOS median from 43 to 41 by March 31, 2026
										4)Promptly identify and designate ALC clients	Team reviews client status at daily Client Flow meetings and weekly JDOT meetings to identify ALC status of clients.	Time interval from when a client is recommended for ALC to when they are designated ALC is monitored.	Reduce LOS median from 43 to 41 by March 31, 2026

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Equity	Equitable	Percentage of New Admissions (Registrations) Who Have Received a Self-ID	Custom	% / New Client Admissions/ Registrations	Local data collection / July 2025 to March 2026	Hospital	CB	85.00	SJCG Standard of Excellence	1)Establish self-identity (Self-ID) process during admission/intake.	a. N'doo'owe Binesi works with clinical areas to use process mapping to create a Self-ID process for each clinical area. b. Manager of each clinical area communicates Self-ID process to staff. c. Self-ID compliance audit process (tool and reporting schedule) developed by planning & performance (with input from clinical team and IH) to monitor compliance by end of Q1.	a. All clinical areas have a self-id process in place by Q1 2025/26. b.80% staff are confirmed to be provided with communication on the self-ID process by end of Q1 2025/26. c. Clinical manager conducts audits quarterly (Q2-Q4) to monitor compliance of self-ID process.	We are aiming to achieve the target of 85% of new admissions/intakes have completed the Self-ID question by Q4 2025/2026.
		Percentage of staff who have completed relevant equity, diversity, inclusion, anti-racism education - Repairing the Sacred Circle 1	Custom	% / All SJCG (except LTC)	In house data collection / April 2025 to March 2026	Hospital	19.4	30.00	SJCG 3-year target plan of 30%, 60%, 90%	1)Establish mandatory education plan to provide Repairing the Sacred Circle 1 (RSC 1) to all staff.	a. IH team to Implement communication plan for RSC 1 mandatory education requirement and sessions via email to: all staff (January & April), Managers (March), and the public (April). b. IH team and corporate learning team to include RSC 1 as mandatory education starting April 1, 2025 (available at general orientation and for staff sign up). c. Corporate learning to add RSC 1 to the current Manager LMS Quarterly compliance report.	a. Communication is sent to all identified groups by end of April 2025. b. All employees have RSC 1 added to their LMS dashboard as mandatory education. c. Managers review RSC 1 LMS staff compliance and continue to communicate mandatory expectation.	Improve performance from 19.4% to 30% by March 31, 2026.

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Experience	Patient-centred	"I was involved as much as I wanted to be in decisions about my treatment and support." Response: Strongly Agree	Custom	% / Mental Health, Discharged Inpatient Clients	In-house survey / July 2025 to March 2026	Hospital	CB	CB	Collect baseline to understand current performance	1)Implement Ontario Perception of Care (OPOC) Tool for use to survey clients upon discharge.	Manager/clinical team will develop process to implement the tool and training will be provided to appropriate staff by end of Q1.	Monthly monitoring of the tool (Q2-Q4) will identify 100% of discharged clients will be asked the question identified as the indicator.	Collect baseline data on percentage OPOC tool was administered to clients on the East Wing at discharge.
		"If I had a serious concern, I would know how to make a formal complaint to this organization." Response: Strongly Agree	Custom	% / Mental Health, Inpatient and Discharged Inpatient Clients	In-house survey / July 2025 to March 2026	Hospital	CB	CB	Collect baseline to understand current performance	1)Implement Ontario Perception of Care (OPOC) Tool for use to survey clients upon discharge.	Manager/clinical team will develop process to implement the tool (discharge and during stay) and training will be provided to appropriate staff by end of Q1.	Monthly monitoring of the tool (Q2-Q4) will identify 100% of discharged and active clients will be asked the question identified as the indicator.	Collect baseline data on percentage OPOC tool was administered to clients on the East Wing at discharge and during stay.
		“Did the hospital staff provide you with clear instructions on how to manage your care and treatment after leaving the hospital?” Response: Yes, definitely	Custom	% / Rehab Care, Inpatient and Discharged Inpatient Clients	In-house survey / April 2025 to March 2026	Hospital	52	54.50	5% improvement on current performance	1)Ask follow-up question to discharged clients: “If not, what other support would have been helpful to you and your family to manage your care and treatment after leaving the hospital?”	Follow-up question added to post-discharge call backs by Director, Collaborative Practice and new process communicated to Remote Care Monitoring staff.	Weekly review of post discharge call backs indicate 100% of clients respond with suggestions to the follow-up question.	Increase performance from 52% to 54.5% by March 31, 2026.
										2)Ask current clients: "What support or resources would you and your family need to help manage your care and treatment after leaving the hospital?"	Social worker adds and communicates (via email, daily huddles on 2nd floor) the question to the discharge planning meeting checklist.	Weekly review of discussion from the discharge planning meeting indicates a response from the client/family to the added question.	Increase performance from 52% to 54.5% by March 31, 2026.
										3)Develop annual PODS Education	PODS education is provided to 80% of all inpatient rehab staff and 100% of Quality Practice Councils (QPCs) in April (and annually thereafter).	Quarterly review of PODS process results in an increase in compliance.	Increase performance from 52% to 54.5% by March 31, 2026.
										4)Establish structured discharge medication teaching process.	Clinical Innovation and Pharmacy develops a structured medication teaching process by end of Q1 2025/26 that ensures clients understand their medications before discharge, including education to staff on the process.	80% of all inpatient rehab staff receive discharge mediation teaching process education.	Increase performance from 52% to 54.5% by March 31, 2026.
										5)Establish and monitor parameter of time interval between discharge order and actual discharge.	a) Clinical team to monitor current time intervals via chart audit. b) Clinical team to create parameter based on current time interval and best practice. c) Clinical team to identify gaps for time intervals outside parameter and develop recommended improvement idea action plan from those gaps.	a) 100% of discharges are reviewed monthly and time interval is documented b) Parameter is developed and used to monitor compliance. c) Progress report of action plan reviewed with Inpatient Operation, Clinical & CNE QSR.	Increase performance from 52% to 54.5% by March 31, 2026.
										6)Develop action plan based on information collected from post-discharge call backs.	Clinical teams review post discharge call back surveys monthly to identify gaps and develop improvement idea action plan from those gaps.	Progress report of action plan reviewed with Inpatient Operation, Clinical & CNE QSR.	Increase performance from 52% to 54.5% by March 31, 2026.

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		Interdisciplinary team (including client) develops 2 goals of care within the first 72 hours of admission	Custom	% / Rehab Care, Inpatient (2nd Floor)	Local data collection / April 2025 to March 2026	Hospital	CB	CB	Collect baseline to understand current performance	1)Establish process for developing and communicating 2 client goals of care within the first 72 hours of admission.	Interdisciplinary team meets with the Client/Family within 72 hours of admission where 2 client goals of care are identified. The goals are then added to the client whiteboard.	Whiteboard audits completed by the manager 72 hours after each client admission, identify the 2 goals of care.	Collect baseline data on percentage of client whiteboards that have two (2) client goals of care identified within 72 hours of admission.
Safety	**Safe**	Number of incidents of racism & discrimination reported by staff	Custom	Number / All SJCG (except LTC)	In house data collection / April 2025 to March 2026	Hospital	CB	CB	Validate baseline data to understand current performance	1)Increase staff awareness and utilization of the Incident Learning System (ILS) for reporting incidents of racism and discrimination.	Update ILS to include type of incident "Racism and Discrimination" by IT by April 1, 2025 including communication of change to Management team and staff in April 2025.	All racism and discrimination incidents are captured under this incident type.	Collect baseline data to help inform accurate measures and improvement moving forward; including developing a rating system of non-physical harm to ensure incidents are appropriately recognized and addressed.