St. Joseph's Hospital

2026/27 Quality Improvement Plan
"Improvement Targets and Initiatives"

Quality Lead: Sumeet Kumar, Director of Quality
St. Joseph's Hospital
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St. Joseph's Care Group 35 North Algoma Street Box 3251, Thunder Bay , ON, P7B5G7

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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	Rehab Care (Inpatient) - Active Length of Stay (excluding ALC Days)	Custom	Days / Rehab Care, Inpatient (2nd Floor)	Local data collection / April 2026 to March 2027	Hospital	2N, 2S Median: 40.5 Days	38 Days	6% reduction on Median LOS for 2N, 2S for the period Q1 -Q3, 2025-26 (with 4 Chronic Vent Rooms on 2N excluded)	1. The clinical team will initiate discharge planning in collaboration with client/family within 72 hours of admission 2. To minimize discharge delays, the clinical team will request client/family feedback on what supports or resources they would need to help manage care and treatment after leaving the hospital. 3. The clinical team will promptly identify and designate Alternate Level of Care (ALC) clients	1a. The clinical team will discuss discharge planning with client/family during initial assessment, and determine expected length of stay (ELOS), within 72 hours of admission. 1b. The clinical team will document the ELOS/discharge plan, and update weekly, in Meditech and on the client whiteboard. 2. During the initial client assessment and discharge planning meetings the clinical team will discus with clients/families what supports they may need to manage care needs after leaving hospital. 3. The clinical team reviews clients at weekly care huddles and JDOT meetings to identify ALC status.	1. Weekly whiteboard audits: 80% target of all newly admitted clients have an established ELOS within 72 hours of admission	Reduce median LOS for 2N, 2S from 40.5 days to 38 days by March 31, 2027
		Mental Health (Inpatient) - Active Length of Stay (excluding ALC Days)	Custom	Days / Mental Health, Inpatient	Local data collection / April 2026 to March 2027	Hospital	Median: 91 Days	82 Days	10% reduction from the baseline	1. Pre Wellness Plan meeting between client and PSR Coordinator including discussion about discharge. 2. Focused planning on transitions between services to support discharge. 3. Defining an estimated discharge date for the Wellness Planning meeting.	1. Psychosocial Rehab Coordinator will schedule a discussion with the client within 2 weeks of admission. 2. Current state evaluation of current processes to be mapped in September 2026 in collaboration with the Director, Access and Flow. 3. Discussions with the psychiatrists in Q1 to clarify a process for determining estimated discharge date.	1. Monthly review of the % of clients for whom the wellness planning was completed within 4 weeks of their admission: 90% target	Reduce median LOS from 91 days to 82 days by March 31, 2027.
Equity	Equitable	All Hospital Inpatient Units - Percentage of New Admissions Who Have Received a Self-ID at SJCG	Custom	% / New Client Admissions / Registrations (All Hospital Inpatient Units)	Loca data collection / April 2026 to March 2027	Hospital	2nd Floor Inpatient Rehab: 100%	All Inpatient Rehab & MH: 85%	SJCG Standard of Excellence	1. Roll out manual compliance measure to all units in Inpatient Rehab Care.	1. Manual process developed and piloted on 2nd floor rehab in 2025-26 is working well. The same process will be spread across all inpatient areas in 2026-27.	1. Weekly audit of completed Self-ID forms	To achieve a Self-ID completion of 85% of new admissions in inpatient rehab and mental health units by March 31, 2027.
		All SJCG (except LTC) - Percentage of staff who have completed relevant equity, diversity, inclusion, anti-racism education - Repairing the Sacred Circle 1 (All Staff) *EC	Custom	% / All SJCG (except LTC)	in house data collection / April 2026 to March 2027	Hospital	Apr to Sep 30.2% To date 43.23%	30% annually 60% cummulative	To meet organizational strategic goal of achieving 30%, 60% & 90% in 2025-26, 2026-27, & 2027-28 respectively	1. Offer additional RSC session in the Spiritual Gathering Lodge (SGL), including occasional evening/weekend sessions for 24/7 staff.	1. In collaboration with Learning & Development, schedule sessions in Spiritual Gathering Lodge and Learning Management System 2. Promote to staff via the Intranet. 3. Directors to encourage staff to attend RSC. 4. Regular updates with directors on quarterly performance	1. % of staff enrolled in RSC training 2. Monthly tracking of attendance at RSC sessions	Improve performance from 30.2% to 60% by March 31, 2027.

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Experience	**Patient-centred**	Rehabilitative Care (Inpatient) - Interdisciplinary team (including client/family) develops 2 goals of care within the first 72 hours of admission	Custom	% / Rehab Care, Inpatient (2nd Floor)	Local data collection / April 2026 to March 2027	Hospital	2nd Floor: 96%	80%	New indicator for all units except 2N & 2S	1. The clinical team will maintain established processes for developing and communicating 2 client goals of care within the first 72 hours of admission on 2S and 2N. 2. The clinical teams will implement processes for developing and communicating 2 client goals of care within the first 72 hours of admission on all other inpatient units.	1. The clinical team will meet with the client/family within 72 hours of admission and identify 2 client goals of care. The goals of care will be added to the client whiteboard and documented in the client's chart.	1. Weekly whiteboard audits: 80% target of all newly admitted clients have established 2 goals of care within the first 72 hours of admission.	The clinical team (including client/family) develops and documents 2 goals of care within the first 72 hours of admission 80% of the time by March 31, 2027
		Rehabilitative Care (Inpatient) - "Did the hospital staff provide you with clear instructions on how to manage your care and treatment after leaving the hospital?" Response: Yes, definitely *EC	Custom	% / Rehabilitative Care, Inpatient and Discharged Inpatient Clients	In-house survey / April 2026 to March 2027	Hospital	72%	76%	5% improvement on the baseline	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?" 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?" (spread and scale to all units (4th floor not included) 3. Annual PODS Education 4. Develop action plans based on information collected Quarterly from post-discharge call feedback"	1. Included in Remote Care Monitoring process 2. Social worker adds and communicates (via email, daily huddles) the question to the discharge planning meeting checklist. 3. PODS education is provided to 80% of all inpatient rehab staff and 100% of Quality Practice Councils (QPCs) 4. Working group review post discharge call back surveys quarterly to identify gaps and develop improvement idea action plan from those gaps	1. 80% of all inpatient rehab staff receive education on PODS annually 2. 100% of Qualty Practice Councils receive education on PODS annually	Increase performance from 72% to 76% by March 31, 2027.
		Mental Health (Inpatient) - I was involved as much as I wanted to be in decisions about my treatment and support. Response: Strongly Agree	Custom	% / Mental Health, Inpatient and Discharged Inpatient Clients	In-house survey / April 2026 to March 2027	Hospital	Q3: 100%	Baseline	New question from Ontario Perception of Care (OPOC) tool	1. Adopt language from the OPOC tool throughout all MH Rehabilitative services to encourage client participation with planning their care.	1. Throughout their MH Rehab stay, clients will be encouraged to participate in care decisions, with staff consistently reinforcing that clients lead their care planning to the extent they choose. 2. Provide education to staff to adopt the new language.	1. Monthly review of % staff that received education to encourage clients participate in their care decisions	Collect baseline data on percentage OPOC tool was administered to clients on the East Wing at discharge.
		Mental Health (Inpatient) - 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 / April 2026 to March 2027	Hospital	N/A	Baseline	New question from Ontario Perception of Care (OPOC) tool	1. Create a QR code.	1. Posters in place on MH Rehab home areas which provides information for clients about making complaints. To increase comfort for the clients, a QR code will be added to support ease of submitting the complaint directly to the Manager.	1. % of responses received through QR code	Collect baseline data on percentage OPOC tool was administered to clients on the East Wing at discharge and during stay.

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Safety	Safe	All SJCG (except LTC) - Number of incidents of racism & discrimination reported by SJCG staff	Custom	Number / All SJCG (except LTC)	in house data collection / April 2026 to March 2027	Hospital	10	Baseline	New Process initiated in 2025-26. Will use 2026-27 as the base year to strengthen establishment of the baseline.	1. Strengthen a structured quarterly ILS review process with HR, Occupational Health, and Indigenous Health	1. Quarterly meetings will be scheduled with HR, Occupational Health, and Indigenous Health to review ILS reports related to racism and discrimination. 2. Data will be reviewed for consistency, frequency, and emerging patterns over time. 3. Where recurring or notable issues are identified, preliminary action plans or monitoring strategies will be documented. 4. Outcomes, learnings, and any actions taken will be recorded and shared	1. % reviews conducted as scheduled per quarter.	Complete 100% of planned quarterly ILS review meetings to strengthen baseline data collection and inform future improvement initiatives.

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