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

Mississippi River Health Alliance

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
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	Percent of patients who visited the ED and left without being seen by a physician	O	% / ED patients	CIHI NACRS / Apr 1 to Sept 30, 2024 (Q1 and Q2)	597 AGH*	11.72	6	Reduction to align with Small Hospitals Averages.		1)1. Examine definitions of LWBS and current state of data by day of week, CTAS level, time of day, etc. 2. Share data at ED committee meeting and with Chief of ED as needed. 3. Identify strategies with the nursing team to reduce this number through best practices such as waiting room communication, vital signs/pain assessment rechecks, etc. Nursing assignments process for triage, etc.	1. Review at committee meetings, staff meetings, daily huddles, etc.	1. Monthly review of data to determine short term successes of improvements.	1. With focused effort and additional nursing staff in the ED and identification of key strategies the rate should decrease to a level similar to peers.	
						626 CPDMH*	10.32	6							
Experience	Patient-centred	Implementation of Emergency Department Return Visit Quality Program though P4R results.	C	Number / ED patients	CIHI NACRS / Q4 2025/26	597 AGH*	CB	20	Required as part of P4R funding.		1)1. Ensure coded data sent to CIHI as per requirements and timing 2. Development template for tracking and recording cases. 3. Chief of ED to assign responsibility to complete and report audits. 4. Add to ED committee meetings and establish where else summaries are shared.	1. Seek assistance from others already completing these audits.	1. Comparison between reports from CIHI and internal data based on criteria of cases selection. 2. Case reviews for team learnings completed as needed.	1. Ensure all charts completed within the quarter identified. If not meeting 20 charts annually ensure local data collection identifies further potential cases.	
						626 CPDMH*	CB	20							
Safety	Safe	Rate of delirium onset during hospitalization	O	% / Hospital admitted patients	CIHI DAD / April 1 to September 30, 2024 (Q1 and Q2), based on the discharge date	597 AGH*	0	0.00	Number of patients who become CAM positive/total number of admitted patients. Reported through Cerner EMR. Baseline to be determined.		1)1. Education initiatives for physicians, nursing, allied health on the recognition of delirium. 2. Enhanced communication for positive CAM assessments with the entire care team.	1. Conduct post-discharge chart reviews where CAM positive change occurred to determine gaps which will drive education and change management. 2. Report case findings at PtCare/QIRM and MAC.	Create report in Cerner to print quarterly cases where CAM was negative on admission and changed to positive during the admission.	Chart reviews will determine if appropriate care provided by the care team via immediate action to recognize signs and symptoms of delirium, potential causes for each patient, care planning commenced and excellent communication amongst all team members. Follow up will include physician documentation for coding purposes.	
						626 CPDMH*	0	0.00							

Safety	**Safe**	IV Pump Safety. Percent of drug overrides utilized in IV Smart Pumps.	C	% / All acute patients	Local data collection / Q1-Q3 2024/25	AGH & CPDMH ED	49%	40%	To Improve the rate the drug is chosen on IV Smart pump in order to capture safety features embedded in the pump for proper medication doses.		1)1. Continue to examine baseline data and determine target after Q1. 2. Conduct weekly spot audits on IV pumps to determine if drug is selected. 2. Train one other pharmacist to run reports so there is no gap if a LOA occurs.	1. Improve the rate that the proper drug is selected for the infusion. This will improve patient safety with checking limits for dosing of medications.	1. It was suspected that fluid only was chosen based on ordering within the drug library. This was changed in Q2 of 24/25 but no new reports have been run to confirm. Once this has been validated then an improvement rate can be determined.	1. Reports run quarterly by pharmacist to indicate override rates and use of fluid only. 2. Spot checks weekly by managers, team leaders, pharmacists and peers with trends reported at team huddles and analysis completed by unit.	
						AGH & CPDMH M/S	51%	40%							
		Reduce number of inpatient / residents falls per 1000 patient days.	C	% / All acute inpatients and LTC residents	Local data collection / Q1-Q3 2024/25	597 AGH*	13.9	10.42	25% reduction		1)1. Initiate a Falls Task Force that will meet biweekly in order to review data, revise the policy, develop the education plan and examine evidence-based research on falls prevention programs and appropriate metrics (are all falls counted or only those where a falls prevention program would be effective). 2. Continue to mine the data to determine falls with injury rates for reference. 3. Ensure all equipment is suitable and working - ie falls alarms connected to call bells.	1. Ensure falls risk assessments completed on admission, quarterly, post fall and with a change in condition. 2. Falls task force to consist of allied health, nursing, pharmacy, physician, etc. 3. Continue to evaluate the impact of the walking program on falls reduction and mobility maintenance.	1. Total number of patient resident falls as recorded in PRIMS system and not from MDS RAI data to ensure standardization occurs.	1. Monthly review of data with Task Force. 2. Quarterly reporting to quality committees.	
						626 CPDMH*	9.3	6.98	25% reduction						
						54686 FVM*	11.6	8.7	25% reduction						
		Reduce the number of lost time hours from occupational illness/injury.	C	Number / Staff	Local data collection / Average of 2023/24 and Q1-3 2024/25	96688 MRHA*	3651	3468	5% reduction. Importance of getting staff back to the workplace in a timely manner and contributing in a meaningful way is part of the recovery process.		1)1. Abilities Manager position to actively work with managers to identify meaningful work as part of the recovery process. 2. Engagement of broader leadership team in identifying work opportunities in all departments.	1. Review with individuals and at leadership meetings. 2.Discussed at JOHS meetings with union representatives present.	Local data from WSIB website. Important note data will lag behind 4 weeks on average. Will include new claims within the fiscal year, not carry-over hours/claims from previous years.	Reduction by 5% or greater in total lost time hours so as to demonstrate the employers interest in having staff return to work in a timely manner and to continue to contribute in a meaningful way to the workplace.	