DEEP RIVER & DISTRICT HEALTH

2025-2026 Quality Improvement Plan

Improvement Targets and Initiatives

Deep River And District Health, 117 Banting Drive, Deep River , ON, K0J1P0

Deep River and District Hospital

North Renfrew Family Health Team

The Four Season Lodge

All Sectors

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**	ALC Throughput	C	# ALC to LTC designated patients in acute care beds	Local data collection / Most recent consecutive 12-month period (Jan - Dec 2024)	646*	6	Equal to or less than 5 ALC to LTC designated patients in acute care beds	Maintain or improve performance. Current target is 5/16.	Ontario Health atHome	1) Identify barriers to implementation of Estimated Discharge Date (EDD) for admitted patients 2) Education for charge nurses, physician regarding use of EDD 3) Implement process for EDD 4) Evaluate use of EDD for inpatients	1) a) Complete review of operationalization of EDD in Epic 1) b) Plan for Epic education related to EDD for admitted patients 2) a) Provide education for physicians and charge nurses regarding importance of EDD and ALC throughput. 2) b) Education related to documentation of EDD in Epic 3) a) Implement EDD for admitted patients with expectations for completion; implementation of policy to support practice 4) a) Conduct audits to evaluate the use and uptake of EDD for inpatients	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) a) Complete review of operationalization of EDD in Epic in Q1 1) b) Plan for Epic education related to EDD for admitted patients for Q2 2) a) Provide education for physicians and charge nurses regarding importance of EDD and ALC throughput for Q2 2) b) Education related to documentation of EDD in Epic for Q2 3) a) Implement EDD for admitted patients with expectations for completion; implementation of policy to support practice in Q3 4) a) Conduct audits to evaluate the use and uptake of EDD for inpatients in Q4; Complete evaluation by March 31, 2026	
		Number of persons with no primary care practitioner accessing cancer screening	C	Primary Care	Baseline	646*	No baseline	36 persons	To implement a cancer screening clinic day once per quarter (4/year) for persons with no primary care practitioner.	In house data colleciton and reporting; collaboration between organizational department; potential external supports are in development;	Implement Cancer Screening Days for patients with no primary care practitioner.	1) Plan coordinated event for cervical, colorectal, and breast cancer screening 2) Implement cancer screening day 3) Evaluate participation and interest	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) Plan first coordinated event for cervical, colorectal, and breast cancer screening in Q1 2) Implement cancer screening day in Q1 3) Evaluate participation and interest post event in Q1 4) Adjust based on feedback and evaluation, plan additional dates Q2-Q4	
Equity	**Equitable**	Percentage of all part-time and full-time employees who have completed relevant equity, diversity, inclusion, and anti-racism (EDI-AR) education.	O	% / Total number of full-time and part-time employees	Local data collection / Most recent consecutive 12-month period	646*	95% of employees completed virtual EDI-AR training modules in 2024/25; 12% participated in EDI-AR workshop during Leadership Development Institute in 2024/25	100% of employees (full-time and part-time) will have completed EDI-AR training by March 31/26	All employees (full-time and part-time) will complete relevant equity, diversity, inclusion, and anti-racism education	Rainbow Health Ontario	1) All full-time and part-time employees will participate in 2SLGBTQI+ Foundations Course.	1) Collaborate with Rainbow Health Ontario to secure 2SLGBTQI+ Foundations Course for all employees 2) Provide education for all employees, prioritizing full-time and part-time staff 3) Evaluate education and plan for broader EDI-AR implementation across the organization	Progress towards completion of education as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	100% completion of education for all employees (full-time and part-time) by March 31, 2026	

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
Experience	**Patient-Centered**	Number of residents responding positively to: "I participate in meaningful activities."	O	# / Total LTC home residents	In house data, inter-RAI survey / Most recent consecutive 12-month period	54420*	33% (4/12 residents)	66% (8/12 residents)	Current performance = 33% (4/12 residents); Goal is to have 50% increase to achieve 66% (8/12 residents) respond positively to indicator question	None; Survey is conducted annually in-house in Q2, based on inter-RAI Quality of Life Survey;	1) Evaluate nursing restorative program, to sustain resident autonomy and independence 2) Implement Recreation Programming by PSW to ensure activities and programming are consistently delivered as planned.	1) a) Completion of annual Restorative Care Program Evaluation, through LTC-CQI 2) a) Review current state of recreational programming being delivered by PSW in Q1 to assess for barriers 2) b) Provide education for all PSW staff related to recreational programming in Q2 2) c) Develop and audit and feedback process to ensure compliance with programming and goals in Q2 2) d) Implement refresh of recreational programming by PSW in Q3 2) e) Evaluate implementation of refresh in Q3 and Q4	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) 100% of eligible resident have an active restorative program plan in place by March 31, 2026 2) a) Review current state of recreational programming being delivered by PSW in Q1 to assess for barriers 2) b) Provide education to 100% of PSW staff related to recreational programming in Q2 2) c) Develop and educatate 100% of staff on audit and feedback process to ensure compliance with programming and goals in Q2 2) d) Implement refresh of recreational programming by PSW in Q3; goal of 95% of resident activities delivered as planned (tracked on monthly dashboard) 2) e) Evaluate implementation and seek feedback from Food and Recreation Committee related to refresh in Q3 and Q4	
Safe	**Safe**	Rate of workplace violence incidents resulting in lost time injury	O	% / Employees	Local data collection / Most recent consecutive 12-month period	646*	16 incident of workplace violence in 2024/25; 31.25% were physical, 6.25% required medical attention; no lost time as a result.	Reduce impact of workplace violence incidents resulting in injury/lost time; maintain progress from 2024/25	Some incidents require lost time for care & assessment; Goal is to reduce impact;	In house data colleciton and reporting; Potential external supports are in development;	1) Build capacity for staff to respond and reduce incidents and impacts of workplace violence by increasing competency with de-escalation.	1) a) Host violence incident drills bi-annually, including with partners/observers where appropriate 1) b) Incorporate standardized debriefing following all incidents of workplace violence, with opportunities for improve (prevent, harm reduction) shared with departmental teams and leadership 1) c) Review with external partners in responsive behaviour management priority opportunities for education (e.g., non-violent crisis intervention)	Progress towards completion of improvement initiatives as identified, as outlined in methods; reporting to QRS Committee quarterly on progress towards achievement;	1) a) Bi-annual drills held, by March 31, 2026 1) b) Debriefing after incidents is included in monthly dashboard 1) c) 80% of patient facing employees with NVCI training to support de-escalation	