Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 25, 2025

Ontario Health

OVERVIEW

St. Francis Memorial Hospital (SFMH) is a small rural hospital located in Barry's Bay, Ontario, about 2.5 hours west of Ottawa. It serves a catchment area of about 10,000 individuals including the townships of South Algonquin, Madawaska Valley, Killaloe Hagarty & Richards, and the area of Hastings Highlands and Bonnechere Valley. The hospital also has a unique partnership with the Madawaska Communities Circle of Health (MCCH) to enhance partnerships and relationships with community-based partners. The MCCH, which includes Hospitals, Ontario Health at Home, Addiction Treatment Services, Paramedic Services, as well as many other health organizations, holds a collaborative mandate to enhance and support the health of all residents in the Madawaska Valley. To date the MCCH is represented by more than 20 agencies including Algonquins of Pikwakanagan Family Health Team & Community Home Support Services. MCCH also has patient and family representatives.

In 2021, SFMH embarked on a journey to refresh the strategic direction for the organization. Our mission "to provide high-quality, patient centered healthcare in collaboration with our partners" and our vision "to be a leader in health services that are patient centered, integrated and responsive to rural community needs" align with our Quality Improvement Plan (QIP) journey. We have been engaged in the development of a yearly QIP for many years and will continue our journey with the focus on the success of the new strategic plan for the organization.

The mission, vision, values, and strategic direction provide the direction for the delivery of quality health services. The Quality Improvement Plan is aligned with the hospital's four key strategic

directions, with an emphasis on the provision of quality health care services:

Quality of Care:
We are committed to improving the patient and family experience by:
•Working to successfully complete the Emergency Redevelopment project.
•Meeting the targeted objectives on all patient services and patient safety.
•Integrating patient and family experience into planning and decision making.
•Emphasizing performance measurement and reporting, while focusing on patient safety, timeliness, quality and transparency.
•Providing access to care without barriers.

Strength in People:
We are committed to recruiting, developing and retaining qualified staff by:
•Improving recruitment plan ensuring inclusivity.
•Ensuring a healthy and safe workplace.
•Demonstrating and supporting Just Culture, innovation, learning and Continuous Quality Improvement.
•Improving staff engagement.

System Integration:
We are committed to improving our partnerships to increase effective, seamless patient centered care by:
•Demonstrating Ontario Health Team leadership.
•Ensuring a patient centered approach.
•Investing in technological systems to further our Vision.

Financial Performance:
We are committed to maintaining sustainable financial stability by:
•Leading as a resource-conscious health provider.
•Continuing to actively seek improvement through efficiency and sustainability.

ACCESS AND FLOW

At SFMH, we are committed to timely access to care and patient flow to improve outcomes and experience for our patients. In 2024 we began participating in the Pay for Results (P4R) program of Ontario Health. This program supports the reduction of length of stay and improving the patient experience in the Emergency Department. In this year's QIP, we will be focusing on reducing the 90th percentile ED wait time to physician initial assessment, daily average number of patients waiting in the ED for an inpatient bed at 8:00am, and percentage of patients who visited the ED and left without being seen by the Physician.

In addition, SFMH joined the RNAO in a collaborative partnership to become a predesignate hospital under the Best Practice Spotlight Organization (BPSO) initiative. This 3-year journey will assist us in implementing research-driven, best practice guidelines to guide our patient care interventions. In year one, we selected the "Transitions in Care and Services" Best Practice Guideline (BPG). In efforts to implement this BPG, we selected the following indicators, and work took place in 2024 to achieve the targets:

•Medication Reconciliation Completion
•Medication History (Best Possible Medication History [BPMH]) completion
•Hospital discharge follow-up completion (post discharge phone call surveys within one week of discharge)

The team will continue to work on this initiative in the 2025-2026 year.

EQUITY AND INDIGENOUS HEALTH

Health equity refers to the study of causes of differences in the quality of health and healthcare across different populations. SFMH embraces the opportunity to ensure quality of healthcare across different populations.

SFMH participates in the Inclusivity, Diversity, Equity, and Accessibility (IDEA) Committee which meets regularly to support health equity aims. This committee helps the MCCH strive for a diverse and inclusive culture where staff, patients and the community feel welcomed, respected, safe and valued in our environment. This committee provided a cultural event calendar in our bi-weekly communique and recognizes events throughout the year such as Black History Month and the National Day for Truth and Reconciliation.

In addition, the management team at SFMH participated in a Kairos Blanket Ceremony at Pikwakanagan First Nations Elders Lodge in September 2023. This was an experiential workshop to explore the nation-to-nation relationships between Indigenous and non-Indigenous peoples in Canada.

Some initiatives at SFMH to improve inclusion, diversity, equity and accessibility are:
•Patient and Family Advisory Council (PFAC) representation on the IDEA committee.
•Participation in the Regional IDEA Committee.
•In each bi-weekly communique, a cultural events calendar is shared with staff to recognize events throughout the year.
•Active participation in regional initiatives.
•SFMH is committed to providing an inclusive, barrier-free work environment. If an applicant requires accommodation during any

phase of the recruitment process, they can contact Human Resources.
•Managers and Team Leads receive training on Diversity, Equity and Inclusion in the workplace through Surge Learning.
•SFMH provides safe spaces for smudging and culturally important practices.
•Patients are able to self-identify in their MyChart their own gender and pronoun preferences. They also can make changes to this if they wish.

In 2025/2026 SFMH will continue to focus on continued education related to equity, diversity and inclusion for management and leadership.

PATIENT/CLIENT/RESIDENT EXPERIENCE

The Patient and Family Advisory Council (PFAC) was established at SFMH in the Fall of 2015. This council meets regularly, and members provide recommendations to advise ways to inform programs and practices aimed at improving the patient experience and advancing person centred care. PFAC representatives also participate on the following sub-committees:
•Quality, Risk and Safety (QRS)
•Care Team
•Infection Prevention and Control (IPAC)
•Inclusion, Diversity, Equity and Accessibility Committee (IDEA)
In June of 2019, SFMH along with several other organizations, formed the Atlas Alliance and implemented a new Electronic Health Record. PFAC members have been actively engaged in the many change process/activities and have influenced decisions regarding communications for MyChart.

As experts in the patient and family experience, the council is the best position to provide recommendations on improving the planning, delivery, and evaluation of care services within the framework of Patient and Family Centred Care. Their insights, recommendations and advice help to inform programs and practices aimed at improving the patient experience and advancing person centred care.

Members provide recommendations on the identification of health care needs and gaps, input on policies and program development, review, and comment on new or revised materials (i.e., policies, forms, etc.), assist in reviewing and providing feedback on patient satisfaction, promote improved partnerships between patients, families, staff and physicians, and participating in hospital committee work. The council also played an integral role in the hospital's highly successful Accreditation Survey in 2021.

The Patient and Family Advisory Council was pleased to have in-person meetings again, after nearly 2 years of virtual meetings during the pandemic. The PFAC welcomed 3 new members this year and continue to recruit. We continue to appreciate the input of this valuable committee and look forward to continuing this partnership in the 2025/2026 year.

SFMH implemented a new patient satisfaction survey platform, Qualtrics. This collects feedback from our patients who received care in the Emergency Department.

SFMH uses a variety of other approaches to engage patients, families and caregivers such as:
•Nursing makes post discharge phone calls to patients who are 65

and older after they have been discharged. This is an opportunity to gather feedback on the care they received at SFMH. This data is tracked and shared with our Continuous Quality Improvement (CQI) and Quality, Risk and Safety Committee.
•Inpatient and program specific outpatient surveys are also utilized. These survey results are regularly reviewed at Care Team and PFAC for feedback.

SFMH will continue to meet all standards relating to the patient and family centered care. SFMH's PFAC is an active participant in the development of the QIP. They also review and provide feedback on our draft QIP plans. PFAC endorses our QIP annually.

PROVIDER EXPERIENCE

SFMH will champion an environment that positions SFMH as the organization of choice for staff, physicians, volunteers and partners where everyone is empowered to be the best they can be. Our hospital values promote leadership and innovation by all our staff in the development of programs and services.

We will:
•Sustain and enhance an inclusive environment that values and supports diversity, physical and psychological health, safety, continuous learning, and wellness.
•Inspire a culture of mutual respect, empowerment and engagement that encourages collaboration, ownership, and innovation.
•Employ strategies to attract and retain the best possible individuals.
•Communicate clear expectations and provide meaningful recognition to our people.
•Promote opportunities and support ongoing development and education to meet the changing needs of our health care team and community.

The Quality Improvement Plan for 2025/2026 continues to focus on initiatives that will engage all clinicians, leadership, and staff at our organization. Our hospital values promote leadership and innovation by all our staff in the development of programs and services. In the 2025/2026 year SFMH will embark on a new journey to prepare for our next Accreditation planned for winter of 2026.

SFMH continually offers mental health supports that are available through our region and the Employee Assistance Program (EAP) in our weekly communiques. Staff meetings are held regularly for team members to engage and provide feedback. SFMH also has an active Employee Wellness committee, collects provider feedback via surveys, actions items as readily as possible and strives to be an employer of choice. Physician recruitment and other staff recruitment remains a high priority for the senior leadership team and the Board.

SFMH continues to be an active participant and leader at numerous committees formed to move the Ottawa Valley Ontario Health Team forward to ensure the best care for our providers.

SAFETY

The Quality Improvement Plan for 2025/2026 continues to focus on patient safety. SFMH is committed to providing an atmosphere of quality healthcare and safety for our patients and our staff. The hospital has implemented many patient safety initiatives and continually looks for new opportunities for improvement.

Patient Safety is a priority at SFMH. It is one of the quadrants that make up our Quality Framework.
SFMH strives to create a Patient Safety Culture that features:

•Acknowledgment of the high-risk and error-prone nature of health care activities.
•A blame free environment where individuals are able to report errors and near misses.
•An expectation of collaboration to seek solutions and create action plans

SFMH has an extremely robust policy related to patient incidents and critical incidents. A structured process is in place to review all incidents involving key physicians and staff to ensure changes and follow-up take place.
In addition, we collate and analyze fall and medication incidents and present them in our Ensuring Safety for Patients (ESP) poster for staff to review. These summary posters capture the number of incidents, risk level, follow-up actions and ways to improve patient safety for the upcoming quarter. These are posted on departmental quality boards, reviewed during huddles and reported at QRS and CQI.

Patient safety is embedded into the culture of the hospital and part of our Accreditation focus to ensure patient safety remains a top priority. Patient concerns/incidents are reported quarterly to the Board CQI along with the changes made. Patient stories/letters are shared regularly at SFMH Board meetings.

SFMH conducts team meetings, family meetings and joint discharge rounds. This process engages the team, patients, and families in safe and timely discharges.

Violence in the workplace presents a risk to the well-being of SFMH staff, physicians, patients and volunteers. It is everyone's responsibility to prevent violence in the workplace. At SFMH we strive to create a positive environment with mutual respect and open communication. In response to Bill 168 (Act to amend the Occupational Health and Safety Act with respect to violence and harassment in the workplace and other matters), SFMH has updated its violence and harassment policies and programs, employee reporting and incident investigation procedures, and emergency response for violent events, and process to deal with incidents, complaints and threats of violence. Extensive education has taken place for all SFMH staff. Staff in key areas of the hospital have received non-violent crisis intervention training, which includes gentle persuasion approach training and general education on the policies/procedures. SFMH has implemented a robust panic alarm system and recommendations from the Occupational Health and Safety Committee as well as front line staff are actioned as soon as possible.

SFMH continues to work with our paramedic and police partners to ensure safe transitions of care for both mental health and addiction patients requiring care at our hospital.

PALLIATIVE CARE

SFMH is dedicated to delivering high-quality palliative care by focusing on patient-centred approaches, ongoing education, and effective community collaboration. SFMH ensures that people with palliative care needs receive compassionate, effective, and timely

symptom management while supporting patients, families and care partners throughout their journey. This approach aligns with key Ontario Health quality standards, such as the management of pain and symptoms (Quality Statement 6), providing the necessary education to staff, families and care partners (Quality Statement 13 and 8, respectively), and facilitating seamless transitions in care (quality Statement 10).
Examples of specific activities SFMH has completed to support this commitment include:

1.Staff Education Initiatives:
SFMH has provided education on empathy, compassion and fatigue to support healthcare professionals in managing the emotional toll and grief that often accompany the care of palliative patients. Additionally, staff participate in an education session focused on pain and symptom management at the end of life. This ensures ongoing education and competency development (Quality Statement 13). SFMH also collaborates with Hospice to provide educational initiatives for staff.

2.Community Partner Collaboration:
SFMH works in partnership with Madawaska Valley Hospice Palliative Care (MVHPC) to provide care to palliative patients. The 2-bed Hospice suite, with private entrance, is located within St. Francis Memorial Hospital and has been in operation since April of 2015. MVHPC is a non-profit community organization offering residential hospice in a homelike setting. MVHPC staff, professional nursing/PSW, trained volunteers and the family physician work collaboratively to provide 24-hour one on one care. In addition, Registered Nurses from the hospital are available for consultation with families in Hospice as required.

These collaborations foster understanding and learning about the available resources, ultimately supporting seamless transitions in care. As healthcare providers and community members work together, they enhance patient navigation and ensure continuous, coordinated care across settings and providers (Quality Statement 10).
Partner Collaborations Include:
-Madawaska Valley Hospice Palliative Care (MVHPC)
-Champlain Centre for Health Care Ethics
-Champlain Hospice Palliative Care

3.Patient and Family Support and Education:
Comprehensive resources to guide families through the dying process and what to expect after death are available. This offers essential education and support during difficult times and helps families to understand the care process and all the available resources.

POPULATION HEALTH MANAGEMENT

SFMH works towards advancement in population health as an active partner in the Ottawa Valley Ontario Health Team (OVOHT). The population health data available through the OVOHT and supported by analytics continues to drive new and innovative care pathways based on best practices to better serve our aging population targeting the most common chronic conditions, reducing unnecessary ER visits and improving overall health. Renfrew County Public Health and Public Health Ontario are essential partners in this work in addition to the many primary care service providers and external services/health care partners.

SFMH maintains active participation in initiatives across all sectors with OHT partners that include work towards shared quality improvement activities, enhancement in digital services and targeted population health initiatives in primary and acute care. Through the quality working group, SFMH actively participates on the OVOHT collaborative annual Quality Improvement Plan which aims to align individual organizational quality improvement activities with partner organizations.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

The Emergency Department (ED) Return Visit Quality Program builds a continuous structure of quality improvement (QI) in Ontario's ED's. This program is an Ontario-wide audit-and feedback program involving routine analysis of ED return visits resulting in admission. Where quality issues are identified, hospitals take steps to address their root causes. In the ED Return Visit Quality Program, participating hospitals receive data reports that flag two types of return visits:

•Return visits within 72 hours for any diagnosis resulting in admission to any hospital (termed "all-cause 72-hour return visits").
•Return visits within 7 days resulting in admission to any hospital with 1 of 3 key "sentinel diagnoses" *(acute myocardial infarction, pediatric sepsis, and subarachnoid hemorrhage) on the return visit, paired with a set of related diagnoses on the initial visit.

*The sentinel diagnoses listed have a high likelihood of disability or death resulting from a missed or delayed diagnosis; thus, EDs that identify quality issues that have contributed to missed sentinel diagnoses may prevent significant patient harm by addressing these issues.

As a small volume hospital SFMH is just beginning this journey in participating in the P4R Program. Participation and progress with the quality initiatives and improved patient outcomes will result in SFMH having 260K in funding for the ER. Currently this funding in 2024-25 is dedicated to nursing hours in the evening, nursing chart audit and quality lead, Physician Assistant and Nurse Practitioner hours. SFMH is tracking and reporting no to the above indicators at Care Team, Board Quality and Safety Committee through to the Board of Directors. SFMH is also committed to tracking and improving our rates of patients who register, are triaged, and then left without being seen by a provider. Although SFMH has performed well in terms of wait times compared to the rest of the province our patient experience feedback captures frustration, especially among patients with no PCP. Additionally, patients state that an ER visit is very impactful because they lose a day of wages from work for a non-urgent need. SFMH volumes through ER are stable, but the frail elderly/complex population and acuity overall is

quite impactful in the department. SFMH is also tracking via EPIC Department Dashboards the Time to initial Physician Assessment and time to inpatient bed once decision to admit is made. These indicators help with flow, safety, and overall experience. SFMH is working on action plans for the program/interventions to improve performance with indicators.

EXECUTIVE COMPENSATION

Two percent of compensation for executives (defined as Chief Executive Officer, Chief Operating Officer, Chief of Staff, VP of Patient Care Services/Chief Nursing Executive, VP of Corporate Services and VP of Financial Services) is linked to the three indicators below:

1.Percentage of staff who have completed relevant equity, diversity, inclusion and anti-racism education.
2.Rate of workplace violence incidents resulting in lost time injury
3.Medication reconciliation at discharge: total number of discharged patients whom a Best Possible Medication Discharge Plan was created.

The Senior Executive team will be responsible for ensuring success in the three key indicators. Refer to the QIP Workplan for specific performance targets for 2025/2026.

As per the above statement, two percent of executive compensation will be associated with three of the QIP indicators within the SFMH plan.

Indicator data will be reviewed at the CQI Committee quarterly, with regular feedback to the Finance Committee and the Hospital Board of Directors to ensure targets are met.

CONTACT INFORMATION/DESIGNATED LEAD

Sherri Cope, VP of Patient Care Services and Chief Nursing Executive

scope@sfmhosp.com
613-756-3044 ext. 238

Gregory McLeod, Chief Operating Officer
mcleodg@sfmhosp.com
613-756-3044 ext. 231

OTHER

Physician recruitment is ongoing at SFMH. There is an identified need for physicians in our community as we experience tremendous Health Human Resource (HHR) pressures. Attracting and retaining HHR talent is a major priority for both physicians, nursing and allied health groups.

SIGN-OFF

It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on **March 25, 2025**

Kevin Quade, Board Chair

Denise Coulas, Board Quality Committee Chair

Greg McLeod, Chief Executive Officer

Sherri Cope, EDRVQP lead, if applicable

Access and Flow | Timely | Optional Indicator

	Last Year		This Year		
Indicator #1 90th percentile ambulance offload time (St. Francis Memorial Hospital)	**26.00** Performance (2024/25)	**25** Target (2024/25)	**30.00** Performance (2025/26)	**-15.38%** Percentage Improvement (2025/26)	**NA** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

SFMH will continue to monitor and improve the time from decision to admit to inpatient bed and monitor utilization and TAT of lab and x-ray to positively impact on flow in the ER

Process measure

- The Inpatient Team continues to monitor this performance on dashboards and implement strategies for improvement

Target for process measure

- Real-time data used for decision-making and presented to Care Team; charge nurses will ensure MDs prioritize the discharges when rounding.

Lessons Learned

SFMH has experienced significant over capacity issues this past year, and a record number of ALC patients on the inpatient unit with little opportunities for discharge dispositions. The rural geography, high percentage of low income elderly population makes discharge dispositions challenging.

Comment

SFMH experienced an unprecedented number of ED visits and inpatient unit capacity for 2024. This significant increase has created additional challenges for both teams.

Indicator #4

Percent of patients who visited the ED and left without being seen by a physician (St. Francis Memorial Hospital)

Last Year		This Year		
2.80	**5**	**2.04**	**27.14%**	**1.50**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Addition of and NP in the ER on a PT basis has helped improve wait times and patient flow

Process measure

- SFMH continues to collaborate with OVOHT partners and share ER alternatives such as RCVTAC

Target for process measure

- Real-time data will be reviewed and shared with partners

Lessons Learned

NP assistance on very busy shifts in ED has reduced wait times. Improved communication to patients regarding current wait times (projected on TV screen in waiting room) and education regarding seeing priority/urgent cases first.

Access and Flow | Efficient | Optional Indicator

Indicator #2

Alternate level of care (ALC) throughput ratio (St. Francis Memorial Hospital)

Last Year		This Year		
X	**1.75**	**0.80**	**--**	**NA**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Home First Philosophy Sustained; Joint Discharge Rounds will ensure all options are reviewed before deeming a patient ALC

Process measure

- Executive Dashboards will be reviewed regularly, and ALC data will be monitored, including utilization of acute beds. Joint discharge rounds will occur 2X/a week.

Target for process measure

- JDR has an escalation process which includes the Chief of Staff, COO and CNE

Lessons Learned

ALC leading practices as per OH direction are being implemented. Close relationships with Ontario health @ home continue. Limited discharge destinations in a rural community continue to pose challenges with flow.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Earlier identification of those at risk for ALC in the ED.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Assessment scales added at triage. OHH co ordinators facilitating discharge from ED prior to admit to medical unit.

Comment

Lack of appropriate discharge destinations in a rural area significantly impacts discharge abilities. Barry's bay has one of the province's largest population of elderly, many of which who are low income, which further complicates discharge planning.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #6 Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (St. Francis Memorial Hospital)	**17.24** Performance (2024/25)	**15** Target (2024/25)	**24.00** Performance (2025/26)	**39.21%** Percentage Improvement (2025/26)	**40** Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

The IDEA committee meets regularly and bi-weekly newsletters reflect important dates and historical events

Process measure

- Completion rates of education will be reviewed at internal committees

Target for process measure

- Continue to expand this training across the organization

Lessons Learned

All new leaders received DEI education.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Surge learning webinar "Diversity Equity and Inclusion" presented at Management/Team lead meeting.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

9 leaders attended the training.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #8	**CB**	**CB**	**137.00**	**--**	**NA**
Total number of visits to the Emergency Department with a main problem of Mental Health or Substance Use (St. Francis Memorial Hospital)	Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

OVOHT has included this indicator in the cQIP. SFMH will monitor at QRS and Board CQI

Process measure

- Monitor the # of ED visits in which the Community Mental Health Crisis team is consulted and/or the patient is discharged with information related to community resources

Target for process measure

- 100% of MHA patients will be referred appropriately and receive community resources documents.

Lessons Learned

Implemented tracking of patients presenting to ED with mental health and substance use as chief complaint. Did not implement tracking of referrals to community crisis team.

Experience | Patient-centred | Optional Indicator

Indicator #5

Percentage of respondents who responded “completely” to the following 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? (St. Francis Memorial Hospital)

Last Year		This Year		
75.00	**80**	**72.00**	**-4.00%**	**75**
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Increase the frequency and quality of patient education at the bedside with patient, family, and care givers

Process measure

- Review data at Care Team as sub-committee to CQI

Target for process measure

- Improve the quality of the AVS by making and utilizing more smart phrases (EPIC optimization) to ensure discharge information is complete and accessible in an understandable way

Lessons Learned

Severe staffing/HHR shortages created pressures on nursing staff. In addition, significant capacity issues creating pressures to turn over beds quickly. In the fall, many new nurses hired and orienting on the unit which further increased pressures on nursing.

Comment

Stabilizing HHR resources on the inpatient unit will provide nursing with additional time to devote to quality patient education regarding discharge readiness.

Safety | Safe | Optional Indicator

Indicator #3

Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged. (St. Francis Memorial Hospital)

Last Year		This Year		
91.84	100	89.49	-2.56%	93
Performance (2024/25)	Target (2024/25)	Performance (2025/26)	Percentage Improvement (2025/26)	Target (2025/26)

Change Idea #1 ☑ Implemented ☐ Not Implemented

Improve pharmacy involvement related to complex discharges. Inpatient nurses are also responsible for this bedside teaching.

Process measure

- Performance will be monitored using the inpatient safety dashboard.

Target for process measure

- 100% of patients discharged will have had BPMH and medication reconciliation completed and included in their AVS.

Lessons Learned

Physician shortages and the use of many locum physicians created challenges in consistency for completion of Med Rec in the EMR.

Change Idea #2 ☑ Implemented ☐ Not Implemented

Education blitz completed in Fall 2024 for nursing related to completion of BPMH.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Rates of BPMH for nursing significantly increased from Q3.

Change Idea #3 ☑ Implemented ☐ Not Implemented

Education provided to local physicians regarding Med Rec completion in EMR.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

Rates for med rec completion are increasing from Q3 onwards.

Comment

Rates for both BPMH and med rec completion are increasing from Q3 onwards.

	Last Year		This Year		
Indicator #7 Rate of workplace violence incidents resulting in lost time injury (St. Francis Memorial Hospital)	**12.00** Performance (2024/25)	**10** Target (2024/25)	**3.00** Performance (2025/26)	**75.00%** Percentage Improvement (2025/26)	**0** Target (2025/26)

Change Idea #1 ☑ **Implemented** ☐ **Not Implemented**

Leadership will work with the Occupational Health and Safety Committee to provide education and implement additional safety practices

Process measure

- Continued education and auditing related to Gentle Persuasive Approaches and other de-escalation techniques.

Target for process measure

- Data will be reviewed and discussed at huddles and at the Occupational Health and Safety Committee

Lessons Learned

Education provided to staff regarding NVCI, GPA. Leadership working with JOHSC to develop safety plan for inpatient unit. Timely follow up by management and Occupational health for any incidents or near misses reports to identify root causes and initiative preventative measures.

Access and Flow

Measure - Dimension: Timely

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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)	2.04	1.50	reduce number of patients who left without being seen by 0.54%.	

Change Ideas

Change Idea #1 Addition of a Nurse Practitioner to ED during busy/peak times to help reduce wait.

Methods	Process measures	Target for process measure	Comments
Review monthly patient LWBS rates; identify when these LWBS patients were in department (ie at peak times, or nights, etc).	ED team will monitor the performance metrics regularly and problem solve further solutions.	Reduction of percentage of patients who LWBS.	

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / ERNI hospitals: Dec 1, 2023, to Nov 30, 2024/Non-ERNI hospitals: Apr 1, 2024, to Sept 30, 2024 (Q1 and Q2)	2.68	2.50	Providing timely access of ED services is a priority of SFMH. Target chosen represents the availability of the NP to provide assistance in the ED.	

Change Ideas

Change Idea #1 Addition of a Nurse Practitioner on busy Emergency Department (ED) days during peak times to assist physicians with decreased time to Physician Initial Assessment (PIA).

Methods	Process measures	Target for process measure	Comments
The Nurse Practitioner will be scheduled to assist in the ED during certain peak times. Data will be reviewed monthly and presented at the Quality Committee and Medical Advisory committee.	Time in minutes will be measured from time of registration to time of Physician Initial Assessment (PIA).	An additional 2.5 hours	Providing timely access to physicians to our rural community is a priority for SFMH, therefore we are adding this indicator.

Measure - Dimension: Timely

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m.	P	Number / ED patients	CIHI NACRS / Apr 1 to Sep 30, 2024 (Q1 and Q2)	0.58	0.25	Inpatient occupancy continues to rise and ALC numbers are high, limiting discharge possibilities. A reduction in this figure will demonstrate a positive impact on discharge planning on the inpatient unit.	

Change Ideas

Change Idea #1 Implement all possible Ontario health at home directives in the ED to facilitate discharge home vs inpatient admission wherever possible.

Methods	Process measures	Target for process measure	Comments
As above. For example, early involvement of home and community care counsellors, introduction of screening of frail elderly/risk for ALC at triage.	Monitor overoccupancy rates and timing of discharges on inpatient unit; ALC throughput ratio.	Improved ALC throughput ratios. 0.25 patients waiting for bed at 0800.	Challenges with discharge dispositions very challenging in rural areas, leading to increased number of ALC patients and admissions, which causes challenges in flow.

Equity

Measure - Dimension: Equitable

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education	O	% / Staff	Local data collection / Most recent consecutive 12-month period	24.00	40.00	We will expand the education slowly to all staff members in the hospital.	

Change Ideas

Change Idea #1 Education provided at management and team lead meetings regarding Diversity, Equity, Inclusion and anti-racism.

Methods	Process measures	Target for process measure	Comments
Seminars will be provided to team leads and management to ensure all are educated.	Data is reviewed at regular DEI committee meetings.	An additional 25% of team leads and managers will attend DEI education. Education will continue to be expanded to all staff at SFMH.	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following 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?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	72.00	75.00	Survey responses are often low, therefore choosing a modest target increase to monitor performance.	

Change Ideas

Change Idea #1 Manager and Team leads will support/encourage discharge teaching and support.

Methods	Process measures	Target for process measure	Comments
Chart audits/reports from EHR. Qualtrics surveys. Discharge phone calls documentation. Data will be compiled and monitored monthly.	75% of patients surveyed will respond "completely" when asked if they received enough information at discharge.	75% of patients surveyed will respond "completely" when asked if they received enough information at discharge.	Total Surveys Initiated: 2357 Discharge teaching is a focus for both the inpatient unit and the ED. Comprehensive written information packages are provided on the inpatient unit.

Safety

Measure - Dimension: Safe

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Medication reconciliation at discharge: Total number of discharged patients for whom a Best Possible Medication Discharge Plan was created as a proportion the total number of patients discharged.	O	% / Discharged patients	Local data collection / Most recent consecutive 12-month period	89.49	93.00	This is a complex indicator as it requires inputs from multiple departments (pharmacy, nursing, physicians).	

Change Ideas

Change Idea #1 We will work closely with nursing, pharmacy, and physicians to improve the rates of completion for Best Possible Medication History (BPMH) and Medication Reconciliation to ensure patient safety.

Methods	Process measures	Target for process measure	Comments
The Pharmacy and Therapeutics committee and the Quality committee will track and report performance monthly. Reports will be circulated to nursing and physicians for review.	Rates of completion and quality of discharge medication reconciliation will be reviewed at the unit level monthly and quarterly at the Quality/safety committees.	93% of patients will have a quality discharge medication reconciliation complete to ensure optimal patient safety.	

Measure - Dimension: Safe

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
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	X	85.00	Want to increase CAM tool completion by 5%	

Change Ideas

Change Idea #1 Early identification and treatment of delirium results in positive patient outcomes and reduced length of stay.

Methods	Process measures	Target for process measure	Comments
Regular chart audits to ensure completion of delirium assessments will be done by nursing staff.	Rates of completion for the "Confusion Assessment method" scales at admission at every shift.	80% of all patients will have a CAM assessment completed every shift.	The CAM is a powerful tool for detecting and preventing delirium in our patients.

Measure - Dimension: Safe

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of workplace violence incidents resulting in lost time injury	O	% / Staff	Local data collection / Most recent consecutive 12-month period	3.00	0.00	SFMH is committed to providing a safe and violence free workplace for all its staff.	

Change Ideas

Change Idea #1 Ensure that staff receive the education that they require when working with individuals with responsive behaviors for their own safety.

Methods	Process measures	Target for process measure	Comments
Managers and occupational health are to track and follow up on all incident reports involving workplace violence incidents.	Numbers of staff who have completed non-violent crisis intervention training and Gentle persuasive approach training.	Zero injuries resulting in lost time.	Occupational health to be involved in all cases to provide modified duties supporting timely and appropriate recovery and RTW.