Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 17, 2026

SFMH
ST. FRANCIS MEMORIAL HOSPITAL

Ontario Health

OVERVIEW

St. Francis Memorial Hospital is pleased to present our 2026–27 Quality Improvement Plan, which reflects our continued commitment to delivering safe, high-quality, and patient-centred care aligned with our strategic pillar of Quality and our mission and vision. This year's QIP underscores our dedication to improving care for some of our most vulnerable patients—particularly individuals living with dementia, depression, and delirium—as we advance our work toward earning the Best Practice Spotlight Organization designation. We are proud of the progress our teams have achieved, including the launch of our Integrated Caregiver Support Program, informed by experience data, to better support the caregivers who play a vital role in the well-being of this frequently hospitalized population. In alignment with system priorities, this year's plan focuses on improving Access and Flow through targeted work in ED indicators and ALC throughput. We are also enhancing the patient and caregiver experience by improving the clarity and consistency of information provided prior to discharge, ensuring patients and families feel confident in managing care at home and recognizing when to return for urgent assessment. From a safety perspective, we continue to address delirium onset during hospitalization, with strong engagement from our Patient and Family Advisory Council, and we are further reducing falls through strengthened restorative care practices—particularly early mobilization of inpatients—which directly supports our Home First philosophy by helping patients return to baseline or better. Collectively, these initiatives represent our ongoing dedication to excellence and continuous improvement in every aspect of care.

ACCESS AND FLOW

St. Francis Memorial Hospital remains committed to ensuring that every patient receives the right care, in the right place, at the right time through the consistent application of best practices across the care continuum. Our work is grounded in the Alternate Level of Care Leading Practices Guide, which informs our proactive management of hospitalized older adults at risk of delayed transitions. By strengthening the use of Estimated Date of Discharge (EDD), enhancing daily flow huddles, and monitoring ALC throughput indicators, we support earlier identification of discharge needs and reduce avoidable delays. In parallel, we are aligning with Ontario Health's Transitions Between Hospital and Home Quality Standard, using its guidance to shape the planned Enhanced Hospital-to-Home program, which will provide more seamless, coordinated, and supportive transitions for patients returning to their communities. Additionally, the Home First Guiding Principles continue to anchor our approach to patient-centred discharge planning, emphasizing collaborative discussions, early goal-setting, and full exploration of community-based services before considering long-term care placement. Together, these initiatives strengthen our integrated care pathways, enhance patient experience, and reduce unnecessary hospital utilization by ensuring timely, appropriate transitions tailored to each individual's needs.

EQUITY AND INDIGENOUS HEALTH

St. Francis Memorial Hospital is committed to advancing equity, diversity, inclusion, anti-racism, and Indigenous cultural safety through intentional organizational action. In alignment with the healthcare-specific Calls to Action from the Truth and Reconciliation Commission Report, SFMH will implement EDI-AR and Indigenous Cultural Safety training for all team members and leaders to foster culturally safe, respectful, and trauma-informed care. This work is further supported by the adoption of the Equity, Inclusion, Diversity and Anti-Racism Framework and a comprehensive review of the First Nations, Inuit, Métis, and Urban Indigenous Health Framework to guide policy development, service delivery, and partnerships. Change ideas include expanding education and capacity-building initiatives for care teams and leadership, strengthening awareness of systemic barriers, and enhancing practices that honour Indigenous identities, rights, and experiences. Together, these efforts reinforce our commitment to creating an inclusive healthcare environment where all patients receive equitable, culturally safe care.

PATIENT/CLIENT/RESIDENT EXPERIENCE

St. Francis Memorial Hospital is committed to embedding the patient voice into all aspects of quality improvement, using real-time feedback to strengthen care experiences and outcomes. As part of our 2026/27 QIP, SFMH is focusing on two key patient experience indicators: the percentage of respondents who answered “completely” to the question, “Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after leaving the hospital?” and the measure, “Would you recommend the Emergency Department?” These indicators help us understand how effectively we communicate, support safe transitions, and deliver patient-centred emergency care. Survey results are reviewed regularly with clinical teams and leadership to identify opportunities for improved discharge teaching, clearer follow-up instructions, and enhanced communication at every stage of care. Insights from patients directly inform change ideas such as standardized discharge education tools, reinforcing teach-back practices, and strengthening ED service interactions. Through this ongoing engagement, SFMH ensures that patient experience meaningfully shapes priorities and drives measurable improvements across the organization.

PROVIDER EXPERIENCE

St. Francis Memorial Hospital is committed to supporting a positive provider experience and strengthening workforce stability through comprehensive retention and recruitment strategies. SFMH actively participates in programs that build the future workforce, including the Extern Program, the New Graduate Guarantee, the Community Commitment Program for Nurses, and peer-to-peer support in the Emergency Department. We maintain strong partnerships with colleges and universities to host clinical student placements and regularly attend job fairs to promote SFMH as an employer of choice. Recruitment efforts are further supported through Practice Ready Ontario and locum initiatives that help meet clinical staffing needs in rural settings. SFMH is developing a robust Human Health Resources plan to proactively address current and emerging workforce challenges. To ensure staff voices guide improvement, annual workforce surveys are conducted and action plans are created in response to feedback. Additionally, our active Employee Recreation Committee helps foster engagement, wellness, and a sense of community among team members.

SAFETY

St. Francis Memorial Hospital is committed to a proactive, systems-based approach to preventing never events as a core component of our patient safety strategy. As an active participant in Health Quality Ontario's Never Events reporting program, SFMH strengthens accountability, transparency, and learning across the organization. Evidence-based best practices are embedded to reduce key safety risks, including comprehensive pressure injury prevention protocols and targeted initiatives to enhance medication safety. Using real-time electronic health record (EHR) reports, staff receive individualized feedback on client identification accuracy, barcode medication administration (BCMA) compliance, medication scanning performance, and medication reconciliation. These data-driven insights support coaching, reinforce reliable practices, and reduce opportunities for harm. Additionally, our Restorative Care Program ensures patients maintain or improve their functional status during hospitalization, reducing deconditioning and related complications. Through these integrated strategies, SFMH fosters a continuously improving safety culture focused on preventing harm and ensuring high-quality, reliable care for every patient.

PALLIATIVE CARE

St. Francis Memorial Hospital has a long and deeply rooted history of providing high-quality inpatient palliative care, supported by a strong and enduring partnership with Madawaska Valley Hospice Palliative Care. This integrated model includes two hospice beds located on the same unit as the inpatient service, allowing for seamless transitions and shared staffing across care areas to enhance continuity and comfort for patients and families. Our collaborative approach extends into the community, where grief and bereavement counsellors provide compassionate support to patients, families, and caregivers throughout illness, end of life, and the bereavement journey. Palliative care nurses contribute their expertise through ongoing hospital education initiatives, strengthening staff competencies in pain management, symptom control, and holistic end-of-life care. In partnership with Renfrew Victoria Hospital, SFMH is also delivering a Caregiver Support Program that offers both practical caregiving education and psychological support resources.

POPULATION HEALTH MANAGEMENT

As an active member of the Ottawa Valley Ontario Health Team (OVOHT), SFMH participates at every level—from governance to frontline working groups—to advance shared regional priorities. Together, we are working to address social drivers of health that contribute to inequities in access, experience, and outcomes. Using population health data, the OVOHT has identified priority groups including individuals living with chronic disease, people without a primary care provider, and those most affected by socioeconomic barriers. SFMH is also highly focused on the growing number of vulnerable seniors living across our vast rural catchment area, who often face challenges related to isolation, mobility, income, and access to services. Through collaborative planning, integrated models of care, and a commitment to equity, SFMH continues to strengthen the supports needed to improve health outcomes for all residents we serve.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

St. Francis Memorial Hospital successfully completed its inaugural year in the Emergency Department Return Visit Quality Program (EDRVQP), strengthening our capacity to review ED return visits and implement targeted quality improvements. The team developed a structured audit process to review return visits related to diagnosis, communication, and care transitions. What worked well was the collaborative learning approach and the alignment with existing quality improvement work including safe care transitions. Challenges included time constraints for busy ED staff and the need to refine documentation to support consistent root-cause analysis. Insights from the first-year audit directly shaped our 2026/27 improvement priorities, including reducing the percentage of patients who leave without being seen (LWBS) and increasing the consistent use of medical directives to improve time to tests and physician initial assessment (PIA). Change ideas include strengthened physician–nurse communication, care team to patient/family communication, and enhanced patient flow monitoring. Through this work, SFMH continues to embed a culture of learning, safety, and continuous improvement in the ED.

EXECUTIVE COMPENSATION

The following positions are considered executive positions at SFMH: President and CEO, Integrated VP Regional Programs and CNE, Integrated VP Clinical Programs and Ambulatory Care, Integrated VP Corporate Services and CFO, Integrated VP People and Strategy, Integrated VP Capital Planning, Infrastructure and Environmental Services/COO. Some indicators and related performance are tied to executive compensation including: percent of caregivers from RVH/SFMH Caregiver Support Program that responded "yes" these sessions were valuable to , Rate of complaints received from persons receiving care, and EDIA-R education and training.

CONTACT INFORMATION/DESIGNATED LEAD

Mary-Ellen Harris, Integrated VP Regional Programs & CNE (RVH & SFMH)
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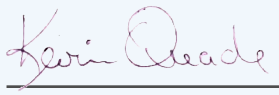
SIGN-OFF

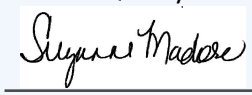
It is recommended that the following individuals review and sign-off on your organization's Quality Improvement Plan (where applicable):

I have reviewed and approved our organization's Quality Improvement Plan on March 31, 2026



Board Chair

Board Quality Committee Chair



Chief Executive Officer

EDRVQP lead, if applicable

Access and Flow | Timely | Optional Indicator

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		
2.04	1.50	2.07	-1.47%	2.05
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- ED team will monitor the performance metrics regularly and problem solve further solutions.

Target for process measure

- Reduction of percentage of patients who LWBS.

Lessons Learned

Although SFMH's LWBS rates are lower than provincial target, we would like to reduce them further. LWBS rates increase in summertime as ED waits increase. Unfortunately, the NP was not able to floated regularly to ED to assist with patient flow. However, the addition of a third RN during busy times on busiest days of the week was implemented. We expected to see improvement in this metric, but did not.

Comment

Examine why the addition of third RN on busy days did not yield improvement as expected.

Access and Flow | Timely | Priority Indicator

Indicator #1

90th percentile emergency department wait time to physician initial assessment (St. Francis Memorial Hospital)

Last Year		This Year		
2.68	2.50	2.80	-4.48%	NA
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

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).

Process measure

- Time in minutes will be measured from time of registration to time of Physician Initial Assessment (PIA).

Target for process measure

- An additional 2.5 hours

Lessons Learned

NP unable to be floated to ED as often as expected due to sustained capacity pressures on Inpatient unit. Difficulties with Physician coverage on inpatient unit necessitated NP remain on unit more often.

Comment

SFMH will need to re examine the change idea of adding the NP to the ED to decrease time to PIA, as likely the issue will remain with NP being needed on the inpatient unit. Ideas to explore can include creating "fast track" areas in the new ED for low acuity patients, exploring additional POCT, leveraging technology, and optimizing medical directives.

Indicator #2

Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (St. Francis Memorial Hospital)

Last Year		This Year		
0.58	**0.25**	**0.60**	**-3.45%**	**0.55**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- Monitor overoccupancy rates and timing of discharges on inpatient unit; ALC throughput ratio.

Target for process measure

- Improved ALC throughput ratios. 0.25 patients waiting for bed at 0800.

Lessons Learned

ALC throughput significantly improved in Quarters 1 and 2 (1.75 and 2.16 respectively). Will continue with ALC best practices implementation to try to maintain ALC througput ratio > 1. Ratios dropped to 0.57 in Quarter 3, with the seasonal increase in volumes in winter of frail elderly and the severe respiratory season that developed.

Comment

Planning to add additional of part time social work to assist with discharge planning. Additional of Clinical manager to also assist with patient flow. Continue to implement and optimize ALC leading best practices.

Equity | Equitable | Optional Indicator

	Last Year		This Year		
Indicator #6	**24.00**	**40**	**CB**	**--**	**CB**
Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (St. Francis Memorial Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- Data is reviewed at regular DEI committee meetings.

Target for process measure

- An additional 25% of team leads and managers will attend DEI education. Education will continue to be expanded to all staff at SFMH.

Lessons Learned

All leaders completed DEI training in 2025. Consider adding DEI training to Surge learning to reach more staff. Ensure all new leaders have DEI training within 6 months of hire.

Comment

Expand and scale DEI training to increased number of staff in 2026.

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		
72.00	**75**	**71.00**	**-1.39%**	**75**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

Manager and Team leads will support/encourage discharge teaching and support.

Process measure

- 75% of patients surveyed will respond "completely" when asked if they received enough information at discharge.

Target for process measure

- 75% of patients surveyed will respond "completely" when asked if they received enough information at discharge.

Lessons Learned

Discharge packages continue to be distributed to patients. Discharge phone calls for patient satisfaction and re admission avoidance going well. Patient information booklet is being developed to assist with this indicator.

Comment

Partnering with Willow publishing to create a new, enhanced patient and family information booklet.

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		
89.49	**93**	**100.00**	**11.74%**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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.

Process measure

- Rates of completion and quality of discharge medication reconciliation will be reviewed at the unit level monthly and quarterly at the Quality/safety committees.

Target for process measure

- 93% of patients will have a quality discharge medication reconciliation complete to ensure optimal patient safety.

Lessons Learned

BPMH and Med reconciliation has been a large focus at SFMH the last two years. BPMH/Med rec is an indicator that was chosen in collaboration with RNAO's Best practice spotlight organization program. Significant gains have been realized, especially with BPMH completion.

Comment

Continue work through BPSO to reach goals.

Indicator #7

Rate of delirium onset during hospitalization (St. Francis Memorial Hospital)

Last Year		This Year		
X	**85**	**0.00**	**--**	**8**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☐ Implemented ☐ Not Implemented ☑ In Progress

Early identification and treatment of delirium results in positive patient outcomes and reduced length of stay.

Process measure

- Rates of completion for the "Confusion Assessment method" scales at admission at every shift.

Target for process measure

- 80% of all patients will have a CAM assessment completed every shift.

Lessons Learned

Data collected for Q3 only as indicator needed to be built in the electronic health record. Q3 (baseline stat) showed 8.6 % occurrence of delirium while in hospital. With this knowledge, targeted implementation strategies will be developed, including the creation of a delirium care plan in the EHR.

Comment

We will continue to work through our collaboration with BPSO/RNAO on the "3 D's" best practice guideline (dementia, delirium, depression). We are creating a template for a delirium plan of care that can inputted into our EHR. We are monitoring rates of CAM completion on admission, which are usually 100%. Continue education initiatives with staff regarding assessment and prevention of delirium.

Indicator #8

Rate of workplace violence incidents resulting in lost time injury (St. Francis Memorial Hospital)

Last Year		This Year		
3.00	**0**	**0.00**	**100.00 %**	**NA**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 ☑ Implemented ☐ Not Implemented ☐ In Progress

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

Process measure

- Numbers of staff who have completed non-violent crisis intervention training and Gentle persuasive approach training.

Target for process measure

- Zero injuries resulting in lost time.

Lessons Learned

We have 0 reported lost time workplace violence incidents. CPI training was offered to all ED staff and multiple inpatient unit staff 2024/25. GPA training is being looked into as well.

Comment

Continue with current implementation strategies and consider GPA training/re training for staff.

Access and Flow

Measure - Dimension: Timely

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	26.60	25.00	This indicator directly correlates with ALC throughput	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Improve overall regional bed pressure awareness

Methods	Process measures	Target for process measure	Comments
The unit manager will attend the daily Regional bed planning meeting and implement overoccupancy protocol	Overoccupancy protocol once developed, will be consistently implemented	Time to inpatient bed will be reduced	

Measure - Dimension: Timely

Indicator #10	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 / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	2.07	2.05	There is no double coverage of MD in peak volume times	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Ensure utilization of existing medical directives and adoption of new directives based on most common presenting complaints

Methods	Process measures	Target for process measure	Comments
Track Left Without Being Seen (LWBS) data	Percentage of patients who complete initial diagnostic orders (lab and/or x-ray) within 15 minutes of arrival	Reduce percentage of patients who LWBS by 1% by March 31, 2027	

Change Idea #2 Consistent staff introductions and use of empathy-based communication

Methods	Process measures	Target for process measure	Comments
Implement "No patient Left Uninformed" through bedside updates every 60 minutes for patients waiting for either diagnostics or a physician's initial assessment. Clear explanation of the triage process "sickest first".	ED Leader rounding resulting in qualitative responses from patients/families/caregivers; ED Leader can share with team at huddles	By March 31, 2027, decrease the percentage of patients who LWBS by 1%	

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with low acuity	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	4.52	4.30	Performing below the provincial average now	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Increase the number of medical directives based on common presenting complaints for low-acuity patients

Methods	Process measures	Target for process measure	Comments
Monitor wait times for ER throughput	Increase the number of medical directives based on common presenting low-acuity patients complaints	Reduce the 90th percentile ED LOS for non-admitted with low acuity by 1% by March 31, 2027	

Measure - Dimension: Timely

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for nonadmitted patients with high acuity	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	5.70	5.50	This indicator correlates with patient experience data for ER LOS	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Monitor wait times for diagnostics

Methods	Process measures	Target for process measure	Comments
Increase the number of medical directives based on common presenting complaints for high acuity patients	Increase the number of medical directives based on common presenting complaints for high acuity patients	Reduce the 90th percentile ED LOS for high-acuity non-admitted patients by 1.0 hours by March 31, 2027, through the implementation of new medical directives and the increased/consistent use of existing ones.	

Measure - Dimension: Timely

Indicator #13	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 / April 1, 2024, to March 31, 2025 (i.e., FY 2024)	0.60	0.55	New programs to reduce ALC pressures are yet to be implemented; new processes to address overcrowding on the inpatient unit are being implemented; this indicator is related to ALC throughput	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Earlier completion of admission decision by MDs, ensuring admission orders are placed in a timely way, and ensuring efficient TOA between the ED and inpatient unit

Methods	Process measures	Target for process measure	Comments
Educate admitting providers on new expectations of timely admission orders within 90 minutes of the decision to admit and implement real-time bed huddles by 0400 to ensure TOA and bed flow.	Monitor the time between the decision to admit, admission orders placed, and TOA	Reduce the daily average number of patients in the ED waiting for an inpatient bed at 0800 AM by 1.5% by March 31, 2027, through improving timelines of admission orders and standardized transfer of accountability processes between ED and inpatient	

Measure - Dimension: Timely

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department length of stay for admitted patients	O	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	39.40	30.00	This indicator directly correlates with ALC throughput (occupancy and patient flow)	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Improve overall team function at 120% occupancy aligning with Ontario Health Directive

Methods	Process measures	Target for process measure	Comments
Implementation of consistent bed flow processes and an overoccupancy protocol	Overoccupancy protocol will be consistently implemented across all shifts	ED LOS for admitted patients will be reduced by 1.3% by March 31, 2027	

Measure - Dimension: Timely

Indicator #15	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate Level of Care (ALC) throughput ratio	C	% / ALC patients	CIHI NACRS / 2026-2027	0.57	1.01	Overall ALC OH Directive is to be less than 8 ALC patients at one time; the throughput ratio, higher is better) means that for every new ALC designation, more are discharged.	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 On Day 1 of admission, discharge planning begins; Expected Date of Discharge is set within 24 hours for all admitted patients; "Home First" as default disposition

Methods	Process measures	Target for process measure	Comments
Implement use of Expected Date of Discharge (EDD) on inpatient unit, and identify at risk patients for Enhanced Hospital to Home Program	% of daily flow huddles completed with barrier/action documentation communicated to the care team, including OH at Home within 72 hours of Admission (WTIS documentation)	Improve ALC throughput ratio by March 31, 2027, by implementing an early standardized ALC avoidance and throughput pathway	New program development: Enhanced hospital-to-home

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	CB	CB	Health care recommendations from the Truth and Reconciliation Report and Anti-Racism are a focus for 2026-27	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Implement EDI-AR & Indigenous Cultural Safety Training focused on the Healthcare Recommendations form the Truth & Reconciliation Report

Methods	Process measures	Target for process measure	Comments
Define relevant education to address the TRC calls to action, by roles within the hospital	% completion ICS module or in-person learning	By March 31, 2027, achieve =95% completion of the EDI-AR learning pathway among executives and =90% among managers	#23–24 call for cultural competency training for all health-care professionals and for health professions education to require courses on Indigenous health issues and anti-racism skills—reinforcing the need to make ICS mandatory for hospital leaders and staff. [rcaanc-cirnac.gc.ca]

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	71.00	75.00	Currently working on implementation of Safe Care Transitions as a best Practice Guideline (BPG), and we will be moving towards implementation of the BPG: People Centred Care. This focus also supports further engagement of patients/families/caregivers in care planning and decision making. Completely: 71% and Quite a bit: 21%	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1	Create a standardized script for staff explaining red flags, expected symptoms, what to do if worsening, and who to contact; build this into After Visit Summaries (AVS) via SMART Phrases where possible.		
Methods	Process measures	Target for process measure	Comments
Provide education and pocket cards highlighting important elements of discharge conversations.	Staff audit score (adherence to discharge communication checklist (Tendable)	By March 31, 2027, increase the percentage of patients who respond "completely" to the post-discharge information question from the current baseline.	Total Surveys Initiated: 200 monitor total surveys returned

Measure - Dimension: Patient-centred

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Would you recommend the emergency department?	C	% / ED patients	CIHI NACRS / 2026-2027	77.00	80.00	trending up in the last few quarters	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Consistent staff introductions and use of empathy-based communication

Methods	Process measures	Target for process measure	Comments
Implement "No Patient Left Uninformed" through bedside updates every 60 minutes for patients waiting for either diagnostics or Physician initial assessment. Clear explanation of the triage process: "sickest first".	ED Leader rounding resulting in qualitative responses from patients/families/caregivers; ED Leader can share with team at huddles	By March 31, 2027, increase the percentage of patients who would recommend the ED from baseline.	

Measure - Dimension: Patient-centred

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of caregivers from the RVH/SFMH Caregiver Support Program who responded "YES" that these sessions were valuable to them/that they learned something helpful.	C	% / Caregivers	Hospital collected data / 2026-2027	CB	CB	So far, this program has only been offered once a week for 6 weeks, and going forward, it will be 1-2 times/month for 12 months (planning stages).	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Use of a standardized caregiver survey & structured program enhancements driven by feedback themes

Methods	Process measures	Target for process measure	Comments
Use a short, low-burden, plain language tool, delivered immediately after each session.	% of sessions with qualitative feedback collected	BY March 31, 2027, increase the percentage of caregivers answering "YES" to the value/learning question from baseline.	

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of complaints received from persons receiving care per 1000 care days/care visits	C	Rate per 1,000 / All inpatients	Hospital collected data / 2026-2027	CB	CB	This indicator aligns with the RNAO BPSO work to implement the People Centred Care Guideline	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	Yes
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Introduce a standardized real-time Unit Manager Rounding process where the leader proactively checks in with patients/families during their care episodes, identifies concerns early, and resolves issues before they escalate into formal complaints

Methods	Process measures	Target for process measure	Comments
The unit manager conducts rounds at least once per shift for multi-day stays	Number of issues resolved via real-time service recovery with no escalation required, which confirms that the new People Centred-Care behaviors are happening consistently.	Establish a reliable baseline complaint rate per 1000 care days/visits over 3 months	

Safety

Measure - Dimension: Safe

Indicator #6	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, 2025 (Q1 and Q2), based on the discharge date (Discharge Date/Time)	0.00	8.00	Current performance is 8.6%	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Implement and educate staff on a standardized set of interventions to embed into care planning activities within 24 hours of admission

Methods	Process measures	Target for process measure	Comments
Develop a structured care plan to use with high-risk clients	% of completed/documented care planning activities/interventions for patients at risk of delirium (preventative actions)	Incidence of new delirium onset	

Measure - Dimension: Safe

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of inpatient falls per quarter	C	Number / All inpatients	Hospital collected data / 2026-2027	25.00	20.00	Restorative care practices are strengthened, and falls are trending down; patient complexity is high	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Rejuvenate the falls prevention program, ensuring consistent risk screening and targeted interventions for high-risk patients

Methods	Process measures	Target for process measure	Comments
Educate teams on universal falls prevention precautions for all patients and ensure family and caregivers are engaged (involved in care planning, understand risk, and have bedside information).	% completion of hourly rounding, including fall-prevention environmental checks using Tendable	By March 31, 2027, reduce the number of inpatient falls per quarter	

Measure - Dimension: Safe

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of patients 65 and over, whose physical function did not decline during hospitalization (maintained baseline or improved)	C	% / Complex continuing care patients	Hospital collected data / 2026-2027	60.00	65.00	All patients over 65 are screened on admission for physical functioning score using a standardized tool, and this aligns well with restorative care practices and the aging population	

Is this indicator related to:	
Emergency Department Return Visit Audits	No
Executive Compensation	No
Pay-for-Results Action Plan	No

Change Ideas

Change Idea #1 Consistent and early completion of Barthel Index score on admission and at discharge; daily mobility goals

Methods	Process measures	Target for process measure	Comments
Early and frequent mobilization/maintain restorative care practices	% of patients with a mobility-focused restorative care goal within 48 hours of admission	By March 31, 2027, increase the percentage of hospitalized patients aged 65+ who maintain or improve their physical function from baseline	