



QUALITY IMPROVEMENT PLAN (QIP) SCORECARD 2025/2026

Vision: Exceptional Care. Always.

Mission: Our Team collaborates to provide exceptional patient-centered care

Values: *ICARE Integrity - Compassion - Accountability - Respect - Engagement*

Instructions: Clicking on the indicator takes the user to additional supporting details.

RECOVERY					
Indicator	Reference	Q1	Q2	Q3	Q4
Emergency Visits - Ambulance Offload Time	QIP	G	G	G	G
Emergency Visits - Wait Time for Non-Admitted Low Acuity	QIP	R	R	R	R
Emergency Visits - Wait Time for Physician Initial Assessment	QIP	R	R	R	R

INTEGRATION					
Indicator	Reference	Q1	Q2	Q3	Q4
Medication Scanning Compliance	QIP	Y	Y	Y	G
Patient Satisfaction Survey	QIP	G	G	G	G

PEOPLE					
Indicator	Reference	Q1	Q2	Q3	Q4
Equity, Diversity, Inclusion and Anti-Racism Education	QIP	Y	R	G	G

Results:

Metric underperforming target
Metric within 10% of target
Metric equal to or outperforming target
Data not available

R
Y
G
N/A

Overall Indicator Performance:

% Indicators equal to or outperforming targets:
% Indicators within 10% of targets:
% Indicators underperforming targets:

Q1	Q2	Q3	Q4
33%	33%	50%	67%
33%	17%	17%	0%
33%	50%	33%	33%

Reference Definitions:

Accreditation - Accreditation Canada
Board - Board Directed
HSAA - Hospital Services Accountability Agreement
MoHLTC - Public Reporting Requirement; Ministry directive
MSAA - Multi-Sector Service Accountability Agreement
OPT - (Annual) Operating Plan Target
Senior Friendly - Senior Friendly Initiative (HSAA)
QIP - Quality Improvement Plan

Indicator: Emergency Visits - Ambulance Offload Time (Mins)(90th percentile)

Strategic Direction: RECOVERY

Definition: The 90th percentile of total minutes elapsed from Ambulance Arrival (Offload) Date/Time to Ambulance Transfer of Care Process Date/Time. AOT = Ambulance Transfer of Care Date/Time minus Ambulance Offload Date/Time. (Current exclusion criteria: Cases where Ambulance Arrival Date/Time is after the Ambulance Transfer of Care Date/Time, cases where Ambulance Arrival Date/Time and Ambulance Transfer of Care Date/Time is unknown (9999) or blank, cases where Ambulance arrival indicator is other than A (air), G (ground), or C (combination), and cases AOT is greater than or equal to 1440 minutes (24 hours).

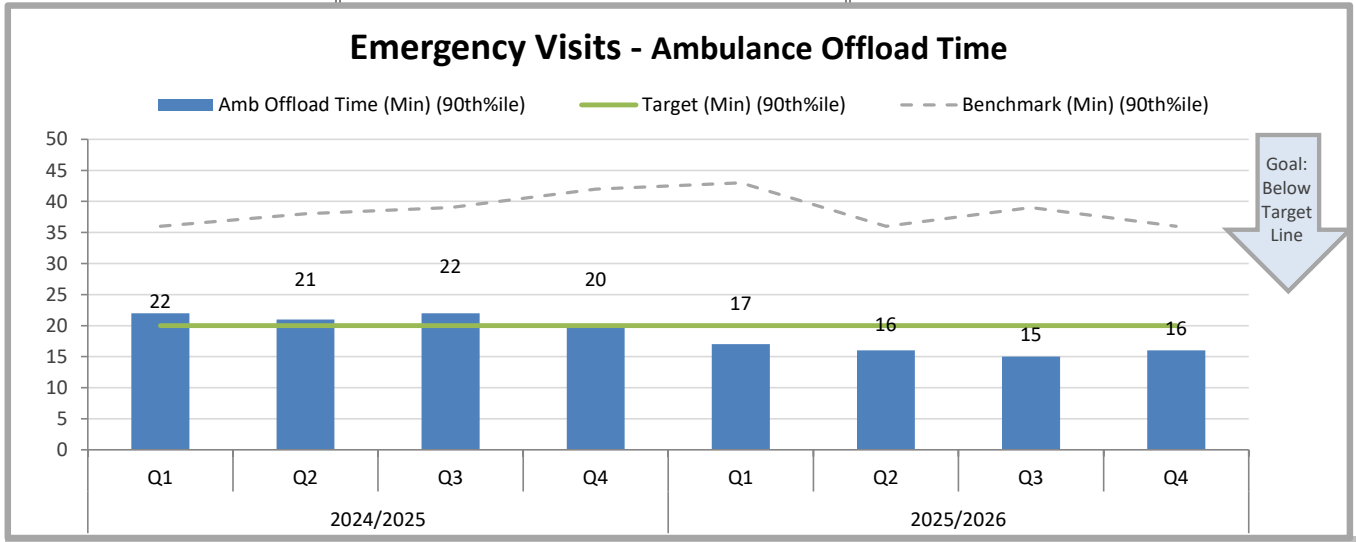
Significance: Ambulance offload times, the time between when a patient arrives at the hospital and the transfer of care, is a critical metric which helps evaluate the efficiency and responsiveness of the healthcare system. These times directly impact the availability of emergency medical services, patient outcomes, and overall system capacity. This indicator can be affected by various factors, including the capacity of emergency departments, the severity of patients' conditions, and inefficiencies within the healthcare system.

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2023-Nov2024) of peer 75 hospital at the 90th percentile.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Amb Offload Time (Min) (90 th ile)	22	21	22	20	17	16	15	16
Benchmark (Min) (90 th ile)	36	38	39	42	43	36	39	36
Target (Min) (90 th ile)	20	20	20	20	20	20	20	20

**Performance Analysis:**

- Q1** Target met. In Q1, the ambulance offload time improved by 15% when compared to prior quarter, decreasing from 20 minutes to 17 minutes. 22.2% of all emergency visits (2,808 out of 12,660) arrived by ambulance.
- Q2** Target met. In Q2, 2,835 out of 12,283 emergency visits (23.1%) arrived by ambulance. This quarter saw an increase of nearly 1% in ambulance arrivals, yet offload times decreased by 1 minute.
- Q3** Target met. In Q3, 3,033 of 12,108 emergency visits (25.0%) arrived by ambulance. Compared to previous quarters, we continue to trend upwards with visits that have ambulance arrivals.
- Q4** Target met. In Q4, there were 2,682 emergency visits that arrived by ambulance. Result performance remained consistent month over month, remaining at 16 minutes across the quarter.

Plans for Improvement:

- Q1** The Emergency Department works closely with our Community Partners to continue to collaborate in maintaining and reducing Ambulance Offload Time (AOT). During Q1, the ED Leadership team continued to collaborate with Decision Support by auditing all delays of 15 minutes or greater for AOT. Collaboration with Clinical Informatics has allowed the ED Leadership team to optimize the data collection and reporting of Fit2Sit, with a direct correlation in reducing AOT. Charge Nurse specific scorecards have been created and shared with the full-time Charge Nurses in the ED to increase awareness of AOT delays.
- Q2** The Emergency Department Leadership team continues to collaborate with EMS and our Decision Support team to optimize the data collection of this metric. A focus will be placed on the ED Clerk group and their workflows regarding ambulance offload times. The part-time Charge Nurse group now has access to monthly scorecards (the same as the full-time Charge Nurse group) to increase awareness of delays.
- Q3** The Emergency Department continues to prioritize safe and timely ambulance offload. Ongoing collaboration with our Decision Support Team and our EMS partners to further refine our process and data quality.
- Q4** The Emergency Department continues to prioritize safe and timely ambulance offload. Ongoing collaboration with our Decision Support Team and our EMS partners to further refine our process and data quality.

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Indicator: Emergency Visits - Wait Time for Non-Admitted Low Acuity (CTAS IV-V) (Hrs)(90th Percentile)**Strategic Direction: RECOVERY**

Definition: The indicator is measured in hours using the 90th percentile, which represents the total time elapsed from Triage/Registration Date/Time (whichever is earlier) to Patient Left ED Date/Time for non-admitted low acuity (CTAS IV-V patients. Exclusions are CDU Length of Stay (CDU LOS).

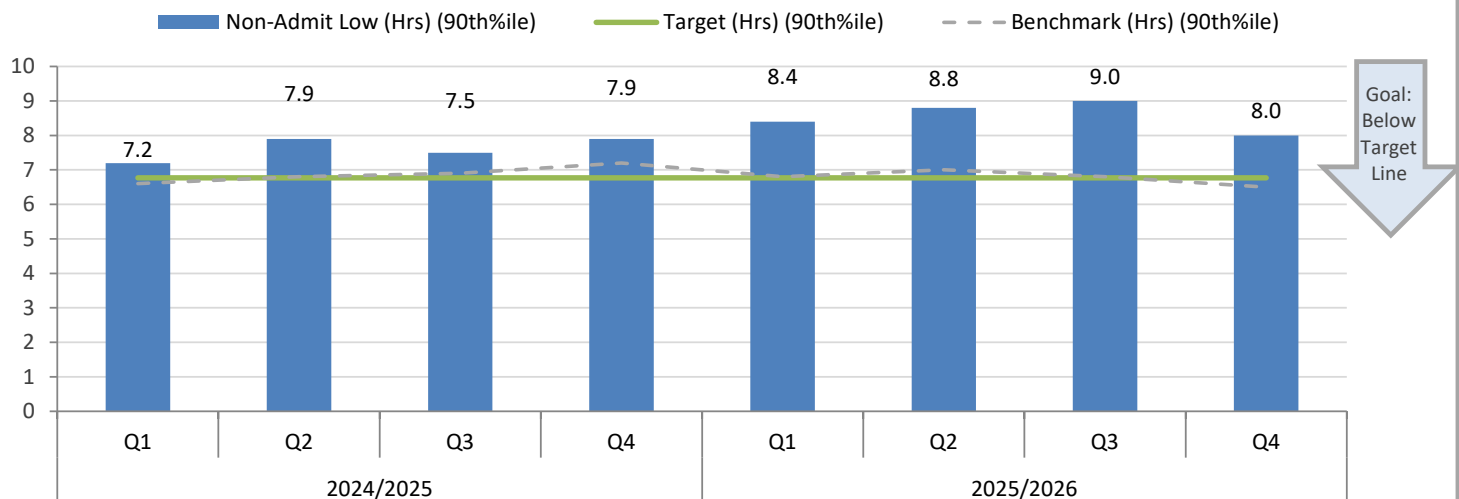
Significance: Time is crucial to the effectiveness and outcomes of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the emergency department in an effort to improve the efficiency and, ultimately, the outcome of patient care.

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2023-Nov2024) of peer 75 hospital at the 90th percentile.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group'

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Admit Low (Hrs) (90 th ile)	7.2	7.9	7.5	7.9	8.4	8.8	9.0	8.0
Benchmark (Hrs) (90 th ile)	6.6	6.8	6.9	7.2	6.8	7.0	6.8	6.5
Target (Hrs) (90 th ile)	6.8	6.8	6.8	6.8	6.8	6.8	6.8	6.8

Emergency Visits - Wait Time for Non-Admitted Low Acuity (CTAS IV-V)**Performance Analysis:**

- Q1** Target not met. In Q1, there were 2,326 low acuity visits (23%) out of 9,987 visits. All months in Q1 were above target (Apr. 9.2, May 8.1, Jun. 7.9) but results are beginning to trend downwards.
- Q2** Target not met. July was the only month below target at 8.4 hours. August (9.2 hours) and September (9.0 hours) were above target but remained within 10% of the goal.
- Q3** Target not met. December recorded the highest wait time this quarter (10.9), compared to October (8.3) and November (8.4).
- Q4** Target not met. Performance exceeded the target in January (8.2) and March (8.7), while February (6.8) met the target.

Plans for Improvement:

- Q1** The Emergency Department continues to explore alternative care methods for patients who are not admitted and visit the ED with a CTAS 4 or 5 (low acuity). Unfortunately Emergency Department Physician staffing challenges have affected this metric.
- Q2** The models identified in Q1 have been explored further. During Q2, we conducted an environmental scan regarding Physician Assistant practices in Ontario EDs. We also conducted in-person sessions to review and optimize our existing Physician Assistant practices within our ED, aiming to improve workflows and reduce non-admitted length of stay in the ED for low acuity visits.
- Q3** Collaboration with IT is ongoing in regards to the care model explored in Q1 for low acuity reason for visits. Ongoing discussions regarding patient flow in See and Treat to optimize patient flow and provide role clarity within nursing and support staff with the intention of reducing length of stay for non-admitted patients with low acuity reason for visits. Emergency Department Physician staffing has recently improved from previous months.
- Q4** We continue to explore the care model for patients in See and Treat (non-admitted patients with low acuity). The EDP group continues to explore their own workflows in order to optimize patient flow in this care area.

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Indicator: Emergency Visits - Wait Time for Physician Initial Assessment (PIA)

Strategic Direction: RECOVERY

Definition: The indicator is measured in hours using the 90th percentile, which represents the time interval between the Triage Date/Time or Registration Date/Time and the Physician Initial Assessment and Non-Physician Initial Assessment (PIA / NPIA) Date/Time in the ED. PIA / NPIA includes; Physicians, Physician Assistants, Dentist, and Nurse Practitioner. Exclusions are: Left Without Being Seen (LWBS), Missing PIA Date/Time, Missing Disposition Date/Time, and Missing Time Left ED Date/Time as per P4R criteria).

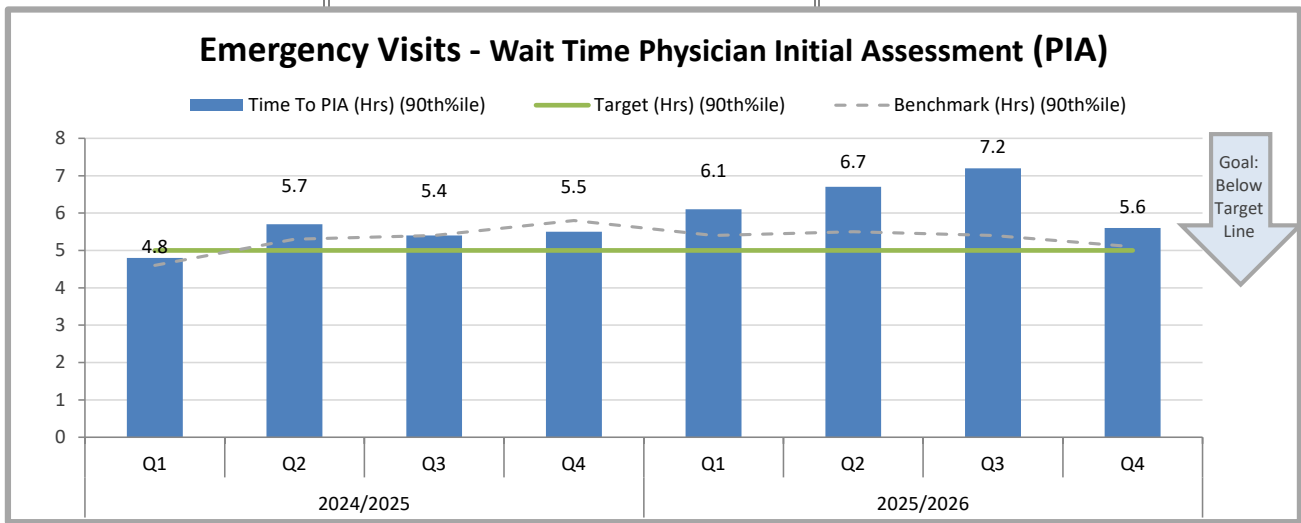
Significance: Time is crucial to the effectiveness and outcome of patient care, especially for emergency patients. In conjunction with other indicators, this can be used to monitor the time patients spend in the ED in an effort to improve the efficiency and, ultimately, the outcome of patient care. Multiple factors can influence the indicator results, including triage level, patient population and availability of resources. The 90th percentile of this indicator represents the maximum length of time that 90% of patients waited in the ED for a Physician Initial Assessment (PIA).

Data Source: Anzer-NACRS

Target Information: Target set in accordance to QIP indicator, to obtain a 10% ranking score improvement of prior P4R year (Dec2023-Nov2024) of peer 75 hospital at the 90th percentile.

Benchmark Information: Benchmark performance is based on quarterly ATC ER Fiscal Year Report 'Medium-Volume Community Hospital Group' results.

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Time To PIA (Hrs) (90 th %ile)	4.8	5.7	5.4	5.5	6.1	6.7	7.2	5.6
Benchmark (Hrs) (90 th %ile)	4.6	5.3	5.4	5.8	5.4	5.5	5.4	5.1
Target (Hrs) (90 th %ile)	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0

**Performance Analysis:**

- Q1** Target not met. Q1 had a total of 10,631 visits, 77% of which occurred during daytime hours (0800-2100hrs). This quarter, we were 13% higher than our benchmark peers (5.4 hrs vs 6.1 hrs).
- Q2** Target not met. In Q2, there were 10,153 encounters, with 76% occurring during daytime hours (0800-2100hrs). Additionally, 568 encounters utilized Physician Assistants.
- Q3** Target not met. Q3 had 9,985 visits, with 76% occurring during daytime hours (0800-2100hrs), which is consistent with the previous quarter. Physician Assistant utilization has increased this quarter (686 vs 568 in Q2).
- Q4** Target not met. Q4 had 9,575 visits, continuing the quarter-over-quarter decline seen in previous quarters. 78% of visits occurred during daytime hours (0800-2100hrs); however, only 401 of these visits utilized the Physician Assistant. Physician Assistant utilization decreased in Q4 compared to previous quarters.

Plans for Improvement:

- Q1** The Emergency Department continues to explore alternative care methods for patients who are visiting through See and Treat. Unfortunately, Emergency Department Physician staffing challenges have affected this metric and have posed a challenge in maintaining and reducing PIA. We continue to work with our Physician Assistant in an attempt to reduce PIA, where possible.
- Q2** The models identified in Q1 have been explored further. During Q2, we conducted an environmental scan regarding Physician Assistant practices in Ontario EDs. We also conducted in-person sessions to review and optimize our existing Physician Assistant practices in our ED to improve workflows and reduce PIA. Unfortunately, Emergency Department Physician staffing challenges have impacted this metric and posed difficulties in maintaining and reducing PIA.
- Q3** Collaboration with IT is ongoing in regards to the model explored in Q1. The ED Leadership team continues to collaborate with the Emergency Department Physician group in regards to PIA. Ongoing discussions regarding patient flow in See and Treat to optimize patient flow and provide role clarity within nursing and support staff with the intention of reducing PIA. Emergency Department Physician staffing has recently improved from previous months.
- Q4** We experienced a decrease in Physician Assistant coverage in the ED in Q4. We continue to explore the care model for patients in See and Treat. The EDP group continues to explore their own workflows in order to optimize patient flow in this care area.

Accountable: VP, Patient Services and Chief Nursing Officer / Director, Emergency Department

Indicator: Medication Scanning Compliance

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of medication administered for which a medication scan was completed for all inpatient and emergency department patients (Excludes Outpatient, Day Surgery, Ambulatory Care).

Significance: Barcode medication administration (BCMA) systems scan a patient's wristband and medication to be given in order to prevent medication errors. BCMA has shown to reduce medication administration errors significantly and to reduce harm from serious medication errors.

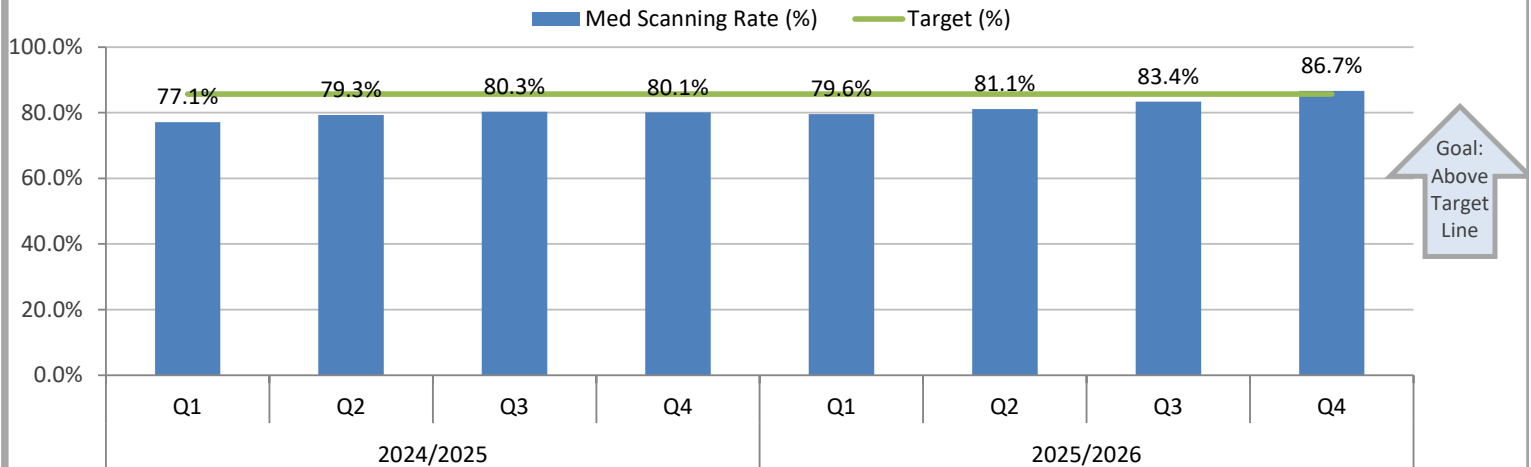
Data Source: Cerner Reporting Portal

Target Information: Set internally at 85.7% in accordance to QIP indicator

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Med Scanning Rate (%)	77.1%	79.3%	80.3%	80.1%	79.6%	81.1%	83.4%	86.7%
Benchmark (%)								
Target (%)	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%	85.7%

Medication Scanning Compliance



Performance Analysis:

- Q1** Target not met. Q1 had 199,320 medications scanned out of 250,448. Of the 9 nurse units, 5 units were within 10% of reaching target.
- Q2** Target not met. Q2 had 207,241 medications scanned out of 255,430, a 1.5% increase in scan compliance compared to previous quarter. Of the 9 nurse units included, 3 were above target, 2 were within 10% of reaching target and 4 were below target.
- Q3** Target not met. Q3 had 208,241 medications scanned out of 249,487. Of the 9 nurse units included, 4 were above target, 3 were within 10% of reaching target, and 2 were below target.
- Q4** Target met. Q4 had 221,081 medications scanned out of 254,958. Of the 9 nurse units included, 5 were above target, 2 were within 5% of reaching target, and 2 were within 10% of reaching target.

Plans for Improvement:

- Q1** Multidisciplinary working group established to identify root causes when medications are not scanning. Ongoing system improvements within medication profiles and the EHR to correct issues in a timely manner.
- Q2** The target was not met; however, improvements have been observed. Targeted education efforts will continue with the identified outlier group to support further progress.
- Q3** Although the target was not met, performance is trending in the right direction. Targeted education and coaching will continue with the identified outliers to support further improvement.
- Q4** Target met. Ongoing targeted education and coaching will occur to sustain practice.

QIP Scorecard FY 2025/2026

[Return to Dashboard](#)

Indicator: Patient Satisfaction Survey

Strategic Direction: INTEGRATION

Definition: This indicator measures the percentage of Inpatient respondents who responded positively (positive response includes "completely" and "quite a bit") (Top2Box) to "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?" (Ontario Adult Inpatient Short Form Survey - Question #7).

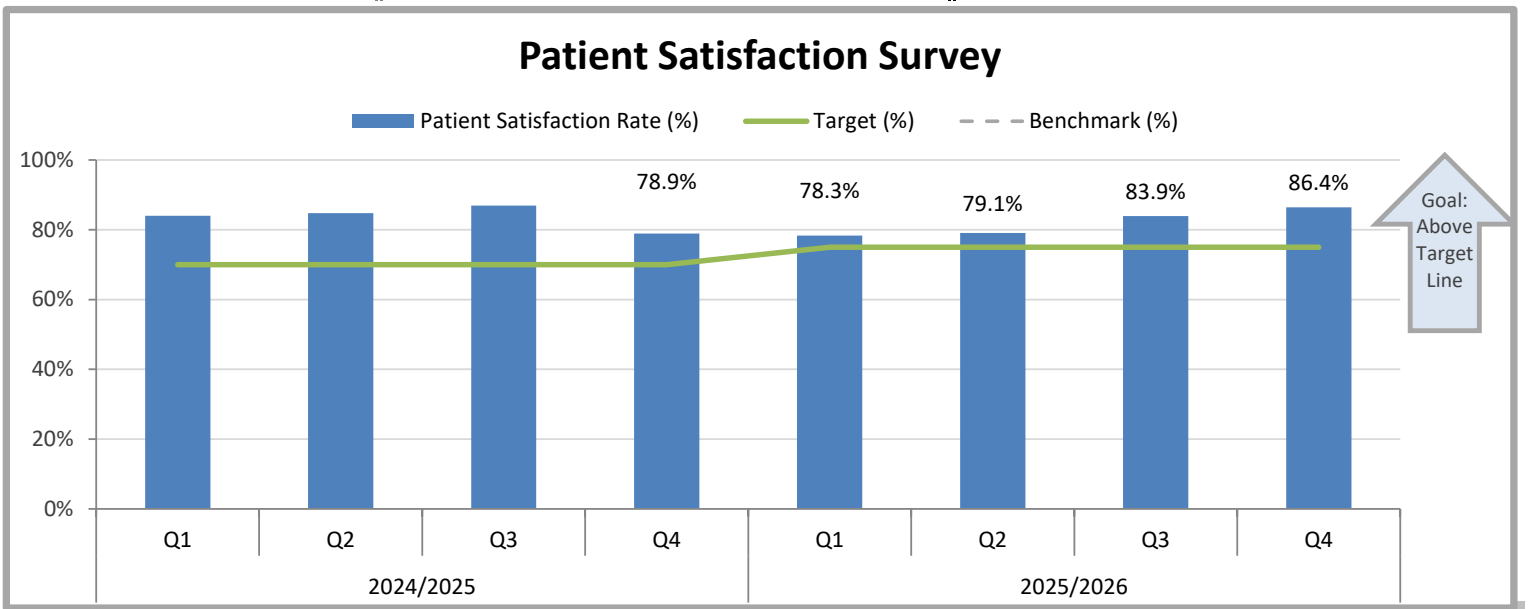
Significance: Taken from HQO, "Patient satisfaction is an important measure of Ontarians' experience with the health care system. Too often, the needs of institutions and healthcare providers come first in Ontario. A paradigm shift is needed, toward a patient-centered health system delivering care that is sensitive to patients' concerns and comfort, and that actively involves patients and family members in shared decision-making about their care."

Data Source: Qualtrics

Target Information: Target set in accordance with QIP indicator, based on prior year's performance.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Patient Satisfaction Rate (%)	84.0%	84.8%	86.9%	78.9%	78.3%	79.1%	83.9%	86.4%
Benchmark (%)								
Target (%)	70.0%	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%



Performance Analysis:

- Q1** Target met. In Q1, 65 out of 83 respondents answered positively, though the overall response rate for Q1 was lower than previous quarters.
- Q2** Target met. In Q2, 72 out of 91 respondents provided positive feedback. The response rate improved compared to the previous quarter.
- Q3** Target met. In Q3, 73 out of 87 respondents provided positive feedback, with the response rate continuing its upward trend.
- Q4** Target met. In Q4, 76 out of 88 respondents provided positive feedback, with the response rate continuing to trend upwards.

Plans for Improvement:

- Q1** Target met, however slight decline. Will continue to monitor and employ change ideas that include Manager Patient Rounding to identify opportunities for early intervention.
- Q2** Target has been met, and performance will continue to be monitored closely to ensure sustained success.
- Q3** Target has been met, with notable improvements since Q2.
- Q4** Target has been met, with improvements since Q3.

Accountable: VP, Patient Services and Chief Nursing Officer

QIP Scorecard FY 2025/2026

[Return to Dashboard](#)

Indicator: Equity, Diversity, Inclusion and Anti-Racism Education

Strategic Direction: PEOPLE

Definition: This indicator measures the percentage of staff (excluding casual) who have completed relevant equity, diversity, inclusion and anti-racism education. Includes executive-level, all management, chief of departments, and volunteers. Performance is cumulative year-to-date.

Significance: Education is essential to help guide and build a culture focused on equity, diversity, inclusion, and anti-racism, and to contribute to better outcomes for patients, families, and providers within the health system. The commitment to addressing racism and discrimination, reducing inequities in the health system, and recognizing that our organizational culture needs to be equitable to contribute to better outcomes for the communities we serve.

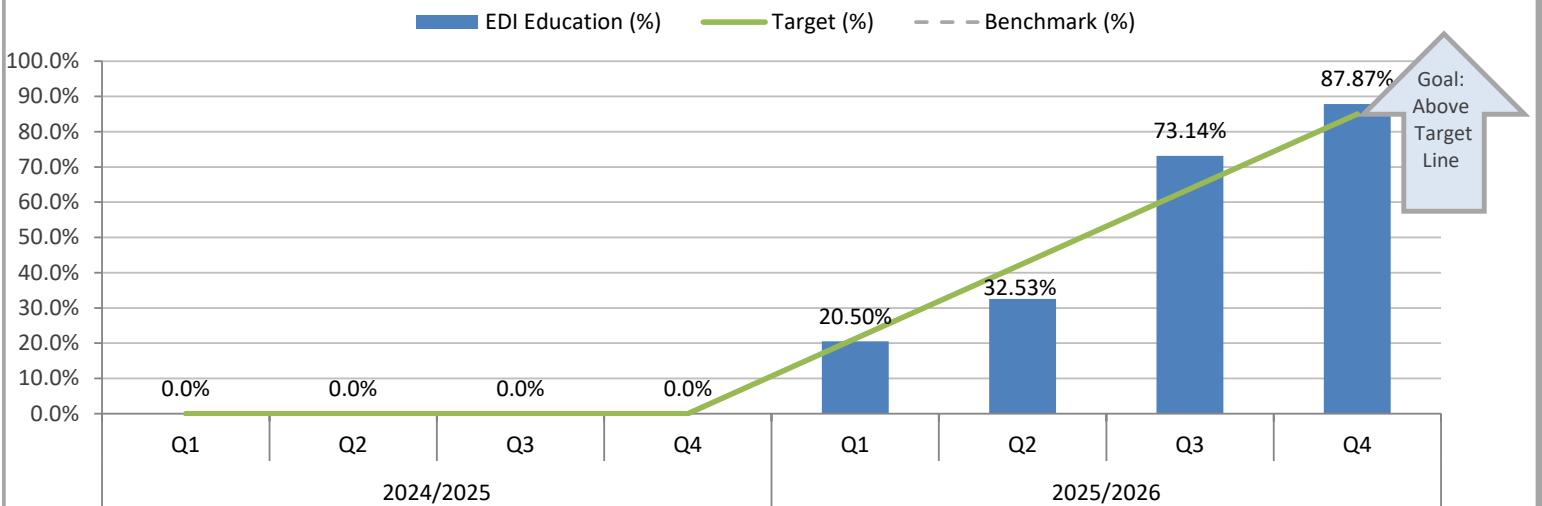
Data Source: Learning Management System (LMS)

Target Information: Target is set internally at 21.25% per quarter (total of 85% annually) in accordance to QIP indicator.

Benchmark Information: N/A

	2024/2025				2025/2026			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
EDI Education (%)	N/A	N/A	N/A	N/A	20.50%	32.53%	73.14%	87.87%
Benchmark (%)								
Target (%)	N/A	N/A	N/A	N/A	21.25%	42.50%	63.75%	85.00%

Equity, Diversity, Inclusion and Anti-Racism Education



Performance Analysis:

- Q1** Target not met. 230 active staff have completed EDI training.
- Q2** Target not met. A total of 418 active staff have completed EDI training.
- Q3** Target met. A total of 956 active staff have completed EDI training.
- Q4** Target met. A total of 1123 active staff have completed EDI training.

Plans for Improvement:

- Q1** Focus on promoting and importance of completing the LMS training module for all staff.
- Q2** Continue to promote EDI training for all staff.
- Q3** Target met, continue to promote EDI training.
- Q4** Target met, continue to promote EDI training.

Accountable: Chief Executive Officer / Director, Human Resources



OUR STRATEGIC DIRECTIONS



[Return to Dashboard](#)