Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

2026-2027

Cornwall Community Hospital
Hôpital communautaire de Cornwall

Ontario Health

OVERVIEW

Cornwall Community Hospital (CCH) is proud to share the 2026/27 Quality Improvement Plan (QIP), continuing our commitment to our strategic plan, Leading Innovative Transformation, and its core priorities for action: Recovery, People, and Integration. The improvement initiatives outlined in this year's QIP reflect our dedication to our ICARE values—Integrity, Compassion, Accountability, Respect, and Engagement—and our vision: Exceptional Care. Always.

CCH remains steadfast in enhancing the quality and safety of care while fostering an environment that minimizes risk for both patients and staff. Our teams work collaboratively and tirelessly to meet the evolving needs of our diverse and growing community. Through data-driven decision-making, evidence-informed practices, and strong partnerships across the health system, we are advancing sustainable improvements that strengthen patient outcomes and experiences.

In 2026/27, CCH will continue to focus on key priorities, including Access and Flow, Equity and Indigenous Health, Patient and Provider Experience, and Safety. The QIP indicators for the coming year reflect these priorities and our commitment to measurable progress. These include reducing wait times to physician initial assessment (PIA), decreasing ambulance offload times, and shortening Emergency Department length of stay for non-admitted patients with low acuity conditions. We will also prioritize advancing equity by increasing the percentage of management staff who complete relevant equity, diversity, inclusion, and anti-racism training. Additionally, we aim to improve communication at discharge, as measured by the percentage of patients who report

receiving adequate information about their health and care on the Patient Experience Survey.

Together, these focused initiatives position CCH to deliver safer, more equitable, and people-centred care for all.

ACCESS AND FLOW

CCH remains focused on initiatives that strengthen access to care and improve patient flow, with the overarching goal of ensuring that patients receive the right care, in the right place, at the right time. The 2026/27 Quality Improvement Plan (QIP) builds on the foundation of prior years and continues to prioritize key performance areas that have a direct impact on patient experience and system efficiency. Specifically, the plan maintains a strong focus on ambulance offload times, physician initial assessment (PIA), and reducing length of stay for non-admitted, low-acuity patients.

Significant progress has been achieved in improving ambulance offload times through close collaboration with community partners, particularly Emergency Medical Services (EMS). This partnership has been instrumental in implementing practical, sustainable changes that support timely patient transitions from ambulance to emergency department care. The strength of this collaboration has allowed CCH to actualize measurable improvements, and ongoing engagement with EMS and other partners will be essential to maintaining and further advancing these gains.

In addition to these efforts, CCH is actively exploring alternative patient flow processes aimed at improving real-time visibility and coordination across care teams. The use of real-time tracking and enhanced communication tools allows for earlier identification of system bottlenecks and operational pressures. By addressing these challenges proactively, CCH can optimize patient movement through the emergency department, improve care delivery efficiency, and support better clinical outcomes. Collectively, these initiatives reinforce CCH's commitment to continuous quality improvement and responsive, patient-centered care.

EQUITY AND INDIGENOUS HEALTH

Advancing health equity and Indigenous health within our community requires intentional, strategic, and sustained action. Our hospital is proud to work in close partnership with the Mohawk Council of Akwesasne to support culturally safe, respectful, and appropriate care for Indigenous patients. This collaboration is reflected in several key initiatives, including the Smudging Ceremony Policy, the Indigenous Patient Navigator role, comprehensive cultural sensitivity training for leaders and staff, and our Land Acknowledgement policy. Together, these initiatives demonstrate our commitment to meaningful engagement and reconciliation in healthcare.

CCH is proud of this ongoing partnership, which has strengthened communication, supported system improvements, and informed planning for future initiatives. These efforts include expanding access to traditional practices and exploring opportunities to create dedicated, culturally appropriate spaces that better support Indigenous patients and families within our hospital setting.

In the past year, CCH launched organization-wide education on Equity, Diversity, and Inclusion (EDI) and anti-racism for all staff. This training established a strong shared foundation and a common understanding of key principles across the organization. As we

move into 2026/27, this groundwork enables us to deepen our efforts through more targeted learning opportunities, particularly for leadership.

In the coming year, CCH plans to deliver focused education for management teams on EDI and anti-racism. This training will support leaders in building greater awareness, knowledge, and insight to enhance both professional growth and personal development. Strengthening leadership capacity in these areas will directly support our ICARE initiatives and foster an inclusive, respectful organizational culture grounded in anti-oppressive and anti-racist practices and policies.

PATIENT/CLIENT/RESIDENT EXPERIENCE

CCH is committed to partnering with patients and families as active participants in their care. This commitment is embedded within our strategic plan through the pillar Inspired by Patients and Care Partners, which guides our approach to delivering high-quality, people-centred care.

Patient experience feedback is essential to identifying opportunities for improvement and enhancing overall satisfaction. CCH gathers this feedback through multiple channels, including patient experience surveys, manager–patient rounding, the Patient and Family Advisory Council (PFAC), and direct engagement through the Patient Experience Department. These mechanisms allow us to gain meaningful insight into the patient journey and better understand the needs, expectations, and perspectives of those we serve. This information informs our continuous efforts to improve service quality and ensures that care delivery remains patient centred.

Our organization is dedicated to ensuring that the voices of patients and caregivers are heard and considered across the full continuum of care and services. Through collaboration with the PFAC, patients and caregivers actively contribute to quality improvement initiatives by sharing lived experiences and offering practical recommendations. Over the past year, PFAC members have played a key role in several initiatives, including participating in focus groups for the design of the palliative care suite, contributing to the redesign of patient discharge information, and reviewing patient education resources.

To recognize and highlight these valuable contributions, CCH has introduced the PFAC Seal of Approval. This designation acknowledges PFAC involvement in the development and review of patient-facing materials and underscores our commitment to co-designing care practices that reflect patient and caregiver perspectives.

PROVIDER EXPERIENCE

CCH recognizes that a healthy, engaged workforce is essential to delivering high-quality patient care. Guided by the Hospital Wellness Committee’s Mission, Vision, and Objectives, CCH has implemented innovative, coordinated workplace wellness practices that positively impact recruitment, retention, workplace culture, and staff experience.

The Hospital Wellness Committee plays a central role in advancing employee and physician well-being through a structured, interdisciplinary approach. With representation from senior leadership, frontline staff, physicians, mental health services, communications, and representation from the Equity, Diversity, and Inclusion (EDI) Committee, the Committee ensures wellness initiatives are inclusive, responsive, and aligned with organizational priorities. Annual workplans and budgets support accountability and continuous improvement.

CCH's commitment to wellness strengthens recruitment by positioning the organization as an employer of choice that values psychological safety, work-life balance, and inclusivity. New staff are introduced early to wellness resources, reinforcing a culture of support from the start of employment.

Retention is enhanced through comprehensive wellness initiatives that address physical, psychological, and social well-being. Access to mental health resources, wellness programming, and training supports staff resilience and helps mitigate burnout in a demanding healthcare environment.

These initiatives also contribute to a positive workplace culture grounded in trust, respect, and engagement. Open communication, leadership involvement, and peer support foster a sense of belonging and shared responsibility for well-being.

Through the work of the Hospital Wellness Committee, CCH continues to enhance staff experience, strengthen workforce sustainability, and support the delivery of safe, compassionate patient care.

SAFETY

Never Events are serious, largely preventable patient safety incidents that should not occur when evidence-based safeguards and systems are properly implemented. These events can result in significant patient harm and undermine trust in healthcare delivery. CCH demonstrates its commitment to transparency, accountability, and continuous quality improvement through voluntary participation in Never Event Reporting. By openly reporting and reviewing these incidents, the organization strengthens its ability to identify system gaps, implement corrective actions, and prevent recurrence, ultimately fostering a strong culture of patient safety.

Recognizing that medication errors represent a significant and preventable risk to patient safety, the 2025/26 Quality Improvement Plan (QIP) placed a focused emphasis on medication safety through increased barcode medication scanning compliance. Medication-related incidents are among the most common contributors to Never Events, making this initiative a critical component of harm reduction efforts. The barcode medication administration system leverages technology to verify the "five rights " of medication administration—right patient, right medication, right dose, right route, and right time—thereby reducing reliance on manual processes and minimizing human error.

Improving scanning compliance supports safer medication practices, enhances nursing workflow efficiency, and strengthens real-time verification at the point of care. Consistent use of barcode scanning reduces the likelihood of adverse drug events, near misses, and preventable harm, directly aligning with the principles of Never Event prevention. This initiative reinforces CCH's proactive

approach to patient safety, ensuring that lessons learned through Never Event reporting translate into meaningful system improvements and safer care outcomes for patients.

PALLIATIVE CARE

In alignment with the Quality Standard and evidence-based best practice guidelines for palliative care, CCH continues to advance this important work through our dedicated Palliative Care Committee. The committee brings together a diverse and collaborative membership, including frontline clinicians, clinical management, and patient and family advisors, ensuring that multiple perspectives inform planning and decision-making. This interdisciplinary approach reflects our commitment to delivering compassionate, person-centred care that is grounded in both clinical excellence and lived experience.

Over the past year, the committee has focused on identifying and assessing the evolving needs of patients and families facing serious illness. Most recently, members facilitated a focus group session with representatives from the Patient and Family Advisory Council to explore options for the development of a new Palliative Care Suite. Feedback from patients and families has been instrumental in shaping a vision for a dedicated space that prioritizes comfort, dignity, privacy, and meaningful connection.

The proposed Palliative Care Suite will offer a calm and welcoming environment designed to support patients and their loved ones during some of life's most vulnerable moments. By creating a space that accommodates family presence, quiet reflection, and holistic supports, CCH aims to enhance the overall care experience. This initiative reflects our recognition that high-quality palliative care must address not only physical symptoms, but also the emotional, spiritual, cultural, and social needs of patients and families. Through continued collaboration and thoughtful planning, CCH remains committed to strengthening palliative care services and ensuring compassionate support at every stage of illness.

POPULATION HEALTH MANAGEMENT

At CCH, in collaboration with Recovery Care, a first-dose Suboxone program was implemented to better serve the unique health and social needs of the community. This initiative represents a shift from traditional emergency responses focused solely on acute symptom management or overdose reversal. By initiating treatment in the Emergency Department (ED), the program aims to reduce repeat emergency visits, ease strain on emergency services, and improve long-term outcomes, reinforcing CCH's commitment to compassionate, safe, and stigma-free care for individuals ready to begin treatment.

Suboxone programs in the ED are designed to support individuals with opioid use disorder at a critical point of care by initiating treatment and connecting them to ongoing recovery services. This program takes a comprehensive approach that addresses both the physical and psychological aspects of opioid use disorder, helping patients begin their recovery journey safely and effectively.

A key component of the ED-based Suboxone program is the administration of a first dose of Suboxone-containing buprenorphine to patients experiencing early opioid withdrawal and who are ready to start treatment. This medication helps reduce withdrawal symptoms and cravings, making it easier for patients to engage in recovery. Naloxone is also provided to prevent misuse

and reduce the risk of overdose. In many cases, patients receive a prescription for continued use and are referred to community-based harm reduction clinics for follow-up care.

Behavioral health assessments are often included to evaluate readiness for treatment and to provide brief interventions that support engagement. Referral to recovery-oriented services is another core element, with patients connected to addiction treatment providers, harm reduction clinics, or withdrawal management services for inpatient or outpatient care as needed.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

The preceding year's quality improvement priorities included an increase in collaboration with Community Partners in order to support discharge. Staff in the Emergency Department (ED) have collaborated with Community Paramedicine services to increase awareness of their services within the ED, improve referral pathways, and better support patients at care transitions, such as discharge.

Additionally, the ED has developed a shared workflow with our Recovery Care Centre to introduce first dose suboxone within the ED. This effort works to increase health teaching and patient education provided at discharge to ensure appropriate return visits to the ED

We appreciated the opportunity again this year to review and audit cases of return visits to our ED. Of the 53 audits completed, 20.7% of the return visits to the ED were related to general weakness and/or caregiver burnout. We plan to implement a General Weakness Medical Directive in the ED to ensure that patient's are receiving care from the moment they enter the ED.

Of the cases that were audited, 17% of return visits were related to a mental health reason for visit and an additional 5.6% of return visits were related to substance use. Our team plans to optimize the primary spaces that this patient population group would be located for their ED visit. The intent will be to ensure that patients and their caregivers feel well cared for while in the ED and prepared for discharge (resources readily available, freshly painted spaces, calming artwork, etc.).

The DI/ED Working Group will continue to meet in 2026 to continue the ongoing discussions and collaboration for our shared workflows. The ED has a goal to better understand the workflows in DI to ensure that we are working together on having DI testing completed when appropriate and have the results readily available—this would allow for patients to spend less time in the ED awaiting testing and/or results. This optimization within shared workflows will support improved patient flow, reduce unnecessary delays, and enhance overall patient experience. By aligning processes, clarifying roles and expectations, and identifying opportunities for standardization, we aim to strengthen communication between teams and ensure timely, efficient care delivery. Ongoing monitoring of key metrics and open feedback between DI and ED will help sustain improvements and drive continuous quality enhancement throughout 2026/27.

EXECUTIVE COMPENSATION

Cornwall Community Hospital performance-based compensation plan for the Chief Executive Officer and the individuals reporting directly to this role is linked to achieving targets in the Quality Improvement Plan as per the Excellent Care for All Act (ECFAA) requirements.

The achievement of the annual targets for the Quality Improvement Plan indicators outlined below account for a total of 2% of the overall compensation for the chief executive officer and the executives below. Payments will be determined by assigning comparable weights to each indicator, and the use of a sliding scale for the percentage of target achieved.

President and Chief Executive Officer
Vice-President, Patient Services and Chief Nursing Officer
Vice-President, Community Programs
Chief Financial Officer
Chief of Staff

CONTACT INFORMATION/DESIGNATED LEAD

Kelly Shaw
Vice President Patient Services and Chief Nursing Officer
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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 12, 2026

Alice Wilson-Haramis, Board Chair

Kristen MacDonell, Board Quality Committee Chair

Jeanette Despatie, Chief Executive Officer

Natalie Bourgeois, EDRVQP lead

Kelly Shaw, Vice-President, Patient Services, and Chief Nursing Officer

Access and Flow

Measure - Dimension: Timely

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average Emergency Department length of stay for non-admitted patients with low acuity	C	Hours / ED patients	CIHI NACRS / 2025/26	4.50	4.10	Set at a 10% reduction in last year's performance	

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

Change Ideas

Change Idea #1 Review and improve patient flow and operations within the See and Treat area of the Emergency Department

Methods	Process measures	Target for process measure	Comments
Through collaboration with ED staff, implementation of alternative patient flow processes in See and Treat	Average LOS for non-admitted patients with low acuity	Q1 Development of the alternative patient flow process in See and Treat (developed in previous FY). Q2 Ongoing collaboration with staff in the ED regarding the alternative patient flow process in See and Treat. Q3 Evaluation of the alternative patient flow process in See and Treat. Q4 Adjustments to be made to the alternative patient flow process in See and Treat, based on evaluation completed in Q3. Target to be met.	

Measure - Dimension: Timely

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average ambulance offload time	C	Minutes / Patients	CIHI NACRS / 2025/26	11.00	10.00	Set at a 10% decrease in last year's performance	

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 Improved workflows with Emergency Medical Services and Decision Support for the data collection of transfer of care

Methods	Process measures	Target for process measure	Comments
Target will be met through collaborating with Community Partners, such as Emergency Medical Services (EMS) and Decision Support to review our current shared workflows, including the collection of data.	Average ambulance offload time	Q1 Collaborate with Decision Support to further analyze data (data collection, data quality, etc.). Q2/Q3 Continued collaboration with EMS and frontline staff in the ED to ensure existing quality improvement initiatives are ongoing and to explore potential quality improvement initiatives. Q4 Target to be met.	

Measure - Dimension: Timely

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Average Emergency Department wait time to physician initial assessment	C	Hours / ED patients	CIHI NACRS / 2025/26	2.70	2.40	Set at a 10% reduction in last year's performance.	

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

Change Ideas

Change Idea #1 Review and improve patient flow operations within the See and Treat area of the Emergency Department

Methods	Process measures	Target for process measure	Comments
Review of patient flow and operations within the See and Treat area of the Emergency Department and implement alternative patient flow processes	Average Emergency Department wait time to Physician Initial Assessment (PIA)	Q1 Development of the alternative patient flow process in See and Treat (developed in previous FY). Q2 Ongoing collaboration with staff in the ED regarding the alternative patient flow process in See and Treat. Q3 Evaluation of the alternative patient flow process in See and Treat. Q4 Adjustments to be made to the alternative patient flow process in See and Treat, based on evaluation completed in Q3. Target to be met.	

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	85.00	85% of managers assigned to complete training	

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 Identify and implement targeted, appropriate equity, inclusion, and diversity, and anti-racism training for management

Methods	Process measures	Target for process measure	Comments
Secure training and curriculum and implement scheduled sessions	Management completion of training	85% compliance with appropriate training	

Experience

Measure - Dimension: Patient-centred

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded positively (top 2 boxes) to the following question: Did you receive enough information from the hospital about what to do if you were worried about your condition or treatment after you left the hospital:	C	% / Survey respondents	Local data collection / most recent consecutive 12 month period	80.50	80.00	Remain consistent with current performance	

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 use of Patient Oriented Discharge (POD)

Methods	Process measures	Target for process measure	Comments
Audit the use of POD's through the through the electronic health record system	Number of patients receiving PODS on discharge/number of discharges	75% of admitted patients receive a POD	

Change Idea #2 Consistent clinical manager rounding on patients			
Methods	Process measures	Target for process measure	Comments
Clinical manager to round on minimum 5 patients per month using standard set of questions	Number of patients rounded per month per unit (admitted patients and ED patients)	85% rate of compliance with manager-patient rounding	