QIP: 2025-2026 Progress Report

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Quality Improvement Plan Scorecard 2025/2026

Strategic Goal	Quality Dimension	Indicator	Definition/ Description	Desired Direction	FY25/26 Target	FY25/26 Performance				
						Q1	Q2	Q3	Q4	YTD
Own our role to improve the system	Timely	90th Percentile ED Wait Time to Inpatient Bed	90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department for admission.	↓	40	38.9	41	40	45	41
Champion a culture of exemplary care and deliver clinical excellence	Patient Centred	Patient Experience	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?”	↑	70%	59.1%	60.4%	59.3%	57.4%	57.2%
	Safe	Workplace Violence Incidents Resulting in Lost Time or Healthcare	Rate of reported workplace violence incidents by hospital workers that resulted in a lost-time injury within a 12-month period. Number of workplace violence incidents that result in lost time reported by hospital workers per 100 full-time equivalent workers within a 12-month period, with worker and workplace violence as defined in the Occupational Health and Safety Act	↓	0.3%	0.58%	0.42%	0.36%	0.44%	0.44%
Create an environment where the best experiences happen	Equity	Equity	Percentage of leaders who completed relevant diversity, equity, inclusion, and antiracism education)	↑	100%	N/A	N/A	37.5%	49.2%	49.2%

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Executive Summary

QIP Indicator Name	Change Ideas	Indicator Lead(s)
90th percentile emergency department wait time to inpatient bed	• Transitioning the responsibility of Patient Placement Meeting (PPM) to the Charge Nurses. • Standardized Bullet Rounds • Admission/Discharge Lounge • ED/Inpatient – Weekend strategy • Implement ETOA Process and Dashboard • Transition from McKesson Performance Visibility (MPV) to Meditech Bedboard • Implement Access & Flow Lead Role (Expeditor)	Katrina Scott
Did patients receive adequate information about health and their care at discharge	• Explore alternative ways to deliver discharge information beyond traditional formats • Conduct a corporate analysis of discharge packages across units and ensure they contain sufficient standardized information • Utilize Qualtrics to monitor and improve discharge communication based on patient feedback	Sonia Pagura
Rate of workplace violence incidents resulting in lost-time injury	• Review current VAT tools for opportunities for improvement • Education & Training on WPV Prevention, Transition to Hybrid Approach with Safe Management Group (SMG) and Gentle Persuasion Approach (GPA)	Menka Anand
Percentage of leaders who completed relevant diversity, equity, inclusion, and antiracism education	• Launch a refreshed mandatory DEI e-learning module for all leaders (managers, directors, and ELT)	Chantelle Vernon

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INDICATOR 1: 90TH PERCENTILE ED WAIT TIME TO INPATIENT BED

Definition: *90th percentile wait time (hours) for patients admitted from the ED to an inpatient bed or operating room, where wait time is from Disposition Date/Time until the Date/Time Patient Left Emergency Department (ED) for admission.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Transitioning the responsibility of Patient Placement Meeting (PPM) to the Charge Nurses.	• Training CNs • Standardizing PPM with scripts • Creating structure for PPM on the evenings and weekends • Implementing Evening and Weekend PPM meetings	• Provide CN training by end of February • Create, PPM Scripts for programs/ units as a reference guide • Provide training to CSM to facilitate evening and weekend PPM meeting. • Implement weekend PPM meeting Mar 22, Evening PPM Apr 14	• 80% of perm CNs trained on PPM by April 2025 • 100% implementation of evening/weekend PPM meetings standardized by May 2025	Implemented , Met Target

Results, Successes and Lessons Learned

- All charge nurses and supporting charge nurses trained on PPM. Charge nurses manage flow/bed meetings on weekends and Managers maintain weekday flow support/bed meeting attendance.

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Standardized Bullet Rounds	• Audit bullet rounds (5D, Attendance) • Audit completion/update of EDD and Blaylock	• Completion of EDD and Blaylock • Attendance rate at bullet rounds	• 90% of patients have updated EDD and Blaylock by June 2025	In progress, Improved but not met target

Results, Successes and Lessons Learned

- Bullet round audits and patient discharge audits completed in Q3. Q4 review of data to inform potential change ideas.

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Admission/Discharge Lounge	• Establishing workflow and patient eligibility criteria • Training staff on the process	• Patient eligibility criteria defined • Staff trained on process	• Eligibility criteria defined by March 31, 2025 • 80% of eligible patients use the lounge	Implemented , Met Target

Results, Successes and Lessons Learned

- Project complete. Admission/discharge lounge open and in use on Crisis level 3 or greater surge days. Teams are flexible based on need (pulling out of ED vs discharge awaiting patients).

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INDICATOR 1: 90TH PERCENTILE ED WAIT TIME TO INPATIENT BED

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
ED/Inpatient – Weekend strategy work	• Additional weekend discharge nurse (P4R funding) • Weekend flow physician stipend for 9 month of year (P4R funding)	• Increase discharge nurse coverage on weekends • Increase weekend physician coverage on weekends	• 20% increase in weekend discharges • # of weekend discharges	Implemented , Met Target
Results, Successes and Lessons Learned				
• 17% increase in weekend discharges • 245 more acute weekend discharges from April 1-Dec 1 2025 vs 2024				

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Implementation of ETOA	• Training clinical staff on ETOA process • Monitoring adherence and identifying barrier • Create ETOA dashboard	• # of staff trained (inpatient and ED staff) • Compliance rate of ETOA • ETOA dashboard developed	• ED staff training complete. • % patients transferred to this assigned inpatient bed within 30 minutes of bed being vacated • ETOA dashboard by September 2025 • 80% of full and part- time Inpatient staff training complete by June 2025	Implemented , Met Target
Results, Successes and Lessons Learned				
• eTOA rolled out in April 2025 for all acute inpatient units. Continues successfully.				

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INDICATOR 1: 90TH PERCENTILE ED WAIT TIME TO INPATIENT BED

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Transition from McKesson Performance Visibility (MPV) to Meditech Bedboard	• Build Meditech Bedboard • Create workflows • Train staff	• Have workflows, maps developed for testing in March • Develop training material • Provide staff training	• 100% of workflows/maps developed by May 2025 • Training material developed by June 2025 • 80% of Meditech Bedboard users trained by August 2025	Implemented , Improved but not met target

Results, Successes and Lessons Learned

- Workflows mapped, bed allocation using Meditech bed board. No transition to frontline leaders/staff as there is a requirement for transport/EVS module for full transition.

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Implement AF Lead Role (Expeditor)	• Recruit for Role • Train Expeditor • Co-locate role in the Command Centre to work alongside bed allocator, dispatch, AF team	• Person in role • Training completed	• Person in role as of February 2025 • Training completed by April 2025	Implemented , Met Target

Results, Successes and Lessons Learned

- 2 people in permanent positions. Begin 7 day a week coverage January 5, 2026

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INDICATOR 2: DID PATIENTS RECEIVE ADEQUATE INFORMATION ABOUT HEALTH AND THEIR CARE AT DISCHARGE

Definition: *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?"*

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Explore alternative ways to deliver discharge information beyond traditional formats	• Implement a digital discharge module available via bedside terminals by Q2	• Percentage of patients who receive discharge information via bedside terminals	• 15% of patients complete the digital discharge module before discharge	Implemented, No Improvement

Results, Successes and Lessons Learned

- Most inpatient beds are equipped with bedside terminals, providing patients, families, and caregivers access to education, entertainment, and hospital information. Extensive discussions were held with our vendor to explore opportunities to leverage this technology to support progress on the discharge communication indicator.
- Due to system constraints, variability across clinical programs, and the current configuration of the bedside terminal model, we were unable to implement a standardized digital discharge education module at this time. As an alternative, a standardized discharge communication poster was developed to empower patients and caregivers, prompt questions, and facilitate meaningful discharge conversations. This approach supports consistent messaging and engagement regardless of program or inpatient unit, while broader digital solutions continue to be explored.

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Utilize Qualtrics to monitor and improve discharge communication based on patient feedback	• Analyze survey results to identify trends and gaps in discharge communication. • Use real-time feedback to course-correct and adjust education approaches as needed • Develop a structured quarterly review process where key themes from Qualtrics feedback are analyzed, and action plans are created	• Frequency of structured Qualtrics review sessions conducted.	• Quarterly data reviews conducted with interdisciplinary teams.	Implemented, No Improvement

Results, Successes and Lessons Learned

- We continue to use Qualtrics data to understand overall performance and unit-level trends in order to target interventions where needed. A key success has been the Surgical Program's leadership in championing this work, contributing to stronger engagement and more consistent review of discharge communication practices.

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INDICATOR 2: DID PATIENTS RECEIVE ADEQUATE INFORMATION ABOUT HEALTH AND THEIR CARE AT DISCHARGE

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Conduct a corporate analysis of discharge packages across units and ensure they contain sufficient standardized information	• Conduct a review of all discharge packages across all inpatient units by Q1 • Engage the Patient and Family advisory council to validate that the discharge materials meet patient needs • Identify gaps and inconsistences between units and make any revisions as needed	• Percentage of discharge packages reviewed and standardized across units. • Number of PFAC validation sessions completed	• 100% of units undergo a discharge package review. • 80 % of reviewed materials are validated by PFAC.	Implemented, No Improvement

Results, Successes and Lessons Learned

- A corporate review of discharge packages was completed to understand current practices across inpatient units. While materials were shared with Patient Experience Partners (PXPs) for input and discussion, no discharge practices or materials were changed as part of this phase. Each clinical program continues to use discharge packages tailored to its patient population, resulting in ongoing variation in content and approach.
- A key challenge identified was that each clinical program engages different stakeholders and follows varied discharge practices, resulting in differences in scope, content, and approach. This reinforced the importance of prioritizing standardization of core discharge information and resources, irrespective of program or inpatient unit, to ensure all patients and families receive consistent, essential information at discharge.

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INDICATOR 3: RATE OF WORKPLACE VIOLENCE INCIDENTS RESULTING IN LOST-TIME INJURY

Definition: *Rate of reported workplace violence incidents by hospital workers that resulted in a lost-time injury within a 12-month period.*

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Review current VAT tools for opportunities for improvement	• Review what other tools exist for screening for potential violence. • Review and revise criteria for identification and flagging of high-risk patients	• VAT tool reviewed • Criteria for high-risk patients developed	• VAT tool reviewed by October 2025 • Criteria for high-risk patients developed by March 2026	Not Implemented, No Improvement

Results, Successes and Lessons Learned

- This goal was not completed as initially planned, because further analysis identified that the underlying cause required a broader approach. In collaboration with the Quality team, it was determined through a root cause analysis, that the challenges behind the large number of code whites, is at a program and operational level, rather than directly linked to the VAT. As a result, efforts were redirected towards understanding these factors, ensuring that any future improvement ideas are based on accurate root causes. This supports consistent messaging and engagement regardless of program or inpatient unit, while broader digital solutions continue to be explored.

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Education & Training on WPV Prevention, Transition to Hybrid Approach with SMG	• Identify and determine number of trainers required / who will be the trainers • Determine a roll out plan and timeline for completion for existing staff • Replace training at Orientation for new staff with GPA • Implement 6 mock violent incidents per year (At least 1 of which to be held at RCU)	• Trainers confirmed • Roll out plan developed • GPA established for new staff • Mock incidents implemented	• Trainers confirmed by March 2026 • Roll out plan developed by March 2026 • GPA established for new staff by March 2026 • Mock incidents implemented by March 2026	Implemented, Met Target

Results, Successes and Lessons Learned

- This goal was achieved. Education and training on Workplace Violence Prevention progressed with the transition to a hybrid training approach incorporating GPA, with the first class scheduled for March 20, 2026. Staff were successfully identified and trained to serve as internal trainers to support ongoing program delivery. This change idea will continue into the next year as additional time is required to implement all parts of the training. During introduction, challenges were encountered including union grievances and a Joint Health and Safety Committee (JHSC) recommendation opposing the change. These concerns were formally addressed, and the initiative is continuing to move forward, recognizing that further dialogue and challenges may arise as the rollout progresses.

INDICATOR 4: EQUITY

Definition: Percentage of Leaders Who Completed Relevant EDI and Anti-racism Education.

Change Idea	Methods	Process Measures	Target for Process Measure	Implementation progress
Launch a refreshed mandatory DEI elearning modules for all leaders (managers, directors, and ELT)	• Source eLearning module(s) • Utilize existing forums, trainings, meetings and communication avenues to promote the purpose and encourage the completion of the eLearning module • ELT to set expectations for leaders to complete education as part of their performance/accountability • Send reminders to ensure timely completion • Review completion rate on a quarterly basis	• Bi- monthly and quarterly progress milestones	• 100% of all leaders trained by March 31, 2026	Implemented, In progress

Results, Successes and Lessons Learned

- 91 out of 122 leaders (75%) have completed the training module as of March 24. This rate is expected to increase as we approach the March 31 deadline.

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