Access and Flow | Timely | Optional Indicator

Indicator #12

Percent of patients who visited the ED and left without being seen by a physician (Espanola General Hospital)

Last Year		This Year		
4.78	**4.50**	**4.57**	**4.39%**	**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

Improved communication in Waiting ED waiting about wait times and CTAS Levels

Process measure

- Increased awareness of wait- times and CTAS process

Target for process measure

- Messaging finalized for display by Q2

Lessons Learned

Implementation in Q1 26/27.
Delays in the design Phase.

Change Idea #2 ☐ Implemented ☐ Not Implemented ☑ In Progress

Implementation of medical directives on patients that meet criteria for top 5 ED presentations. This will cause a decrease LOS and wait-times in ED

Process measure

- Monthly reviews of charts of with top 5 presentations with medical directives

Target for process measure

- 80% of chart audits will have appropriate medical directives initiated by the end of Q4

Lessons Learned

Challenges with ability to easily access, pull and review charts in new EMR system.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

ED NP in ED to support access and flow focused on CTAS 4 and 5 patients.

Process measure

- Will review NP stats for # and type of patients seen monthly.

Target for process measure

- collecting base line

Lessons Learned

A collaborative approach with the MD and NP to patient assessments and a focus on CTAS 4 & 5 to balance and support flow.

Comment

We will continue with current work and have implemented daily huddle to support access and flow.

Access and Flow | Timely | Priority Indicator

	Last Year		This Year		
Indicator #7 90th percentile emergency department wait time to physician initial assessment (Espanola General Hospital)	**2.62** Performance (2025/26)	**2.50** Target (2025/26)	**2.50** Performance (2026/27)	**4.58%** Percentage Improvement (2026/27)	**4** Target (2026/27)

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

Development of the Nurse Practitioner role to support access, flow and LOS within the ED

Process measure

- will monitor # and type of patients see per day by NP

Target for process measure

- 10- 15 patients per day

Lessons Learned

A collaborative plan was developed with MD and NP about approach to patient assessments and a focus on CTAS 4 & 5 to balance and support flow.

Change Idea #2 ☐ Implemented ☑ Not Implemented ☐ In Progress

Implementation of medical directives on patients that meet criteria for top 5 ED presentations.

Process measure

- Monthly reviews of charts of with top 5 presentations with medical directives

Target for process measure

- 80% of chart audits will have appropriate medical directives initiated by the end of Q4

Lessons Learned

Challenges with ability to easily access, pull and review charts in New EMR system.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Improved communication in Waiting ED waiting room about wait times and CTAS Levels

Process measure

- Increased awareness of wait- times and CTAS process

Target for process measure

- Messaging finalized for display by Q2

Lessons Learned

Implementation to be completed by Q1 26/27. Delays occurred in the design phase.

Comment

We will continue with current improvement work and have started daily huddles to support access and flow.

Access and Flow | Efficient | Custom Indicator

Indicator #8

Alternate level of care (ALC) throughput ratio (Espanola General Hospital) (Espanola General Hospital)

Last Year		This Year		
1.10	**1**	**1.00**	**--**	**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

Create and implement an information package on LTC home selection, what it means to be ALC, co-pay, community service that are available

Process measure

- # of admitted patients excluding form 1 that have received information about LTC/ALC

Target for process measure

- A pamphlet will be created by the PN and community partners by the end of Q2, and 100% of admitted patients excluding form 1 patients will receive this pamphlet

Lessons Learned

An information package was created and implemented by Q2.

We only provide the information package to ALC status patients, not all patients.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Team to create and implement a rounds template that outlines barriers to discharge, estimated discharge date, patient goals of care

Process measure

- # of ALC patients that have a goals of care assessment completed by the PN involving famiy (SDM) and patient

Target for process measure

- 100% of ALC patients will have a goals of care assessment completed

Lessons Learned

We have implemented a standardized approach to our rounds. Goals of care assessments are being completed on ALC - LTC patients and other ALCs with prolonged hospital stays before transition.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

All patients who meet the criteria for PT referral will have a referral sent on admission

Process measure

- # of admitted patients that qualify for PT are referred

Target for process measure

- 100% of patients who meet criteria for PT will be referred

Lessons Learned

We review PT referrals at rounds and ad hoc for new admissions. If the referral has not be entered by the physician at admission, this gap is rectified in rounds and the charge nurse enters the referral.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

% of patients who meet criteria for the Complex and Palliative Care Team (CPCT) have a referral sent during their admission

Process measure

- % of admissions who have had the early identification tool used for palliative care/ complex.

Target for process measure

- 80% of all patients admitted to acute care that consent and qualify for complex or palliative services will have a referral to the CPCT

Lessons Learned

Qualifying patients who meet criteria are identified in rounds and their consent is obtained for the referral to CPCT.

Comment

We will be continuing work on ALC leading practices to ensure seamless transition to community and/or LTC placement.

Indicator #17

Percentage of patients representing to hospital within 30 days of discharge after hospitalization/ transfer to schedule 1 facility for mental illness or addiction (Espanola General Hospital)

Last Year		This Year		
21.00	**18**	**22.00**	**--**	**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

The Crisis worker in the ED will complete training to support RAAM services in the ED if no one from the RAAM program is available

Process measure

- # of RAAM assessments completed by the crisis worker in the ED

Target for process measure

- 80% of patients requesting RAAM will have consult completed in the ED if FHT services not available

Lessons Learned

Our Crisis worker was on an extended leave, therefore this work was put on hold. The plan was to have them trained to perform RAAM consultations, but that was also delayed due to the leave. They have returned as of Q4 and we will continue this work to achieve targets.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

The crisis worker in the ED will see all mental health presentations Monday-Friday

Process measure

- # of mental health presentations over the number of assessments completed.

Target for process measure

- 80% of mental health patients presenting to the ED will have the appropriate mental health assessment completed in expanse

Lessons Learned

As of Q4 this year we have implemented a referral in Expanse to our crisis working so that this target is more easily tracked.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Improved referral pathways and community resource engagement development with MHA local table

Process measure

- Current state analyzed and data validated.

Target for process measure

- 100% current state analyzed and data validated.

Lessons Learned

MHA community working group established. Data collection and resource repository in preplanning underway

Comment

We will be removing this indicator from our QIP, but will continue to monitor it via internal secondary MHA dashboards. We will be sending our crisis worker for RAAM certification and will be monitoring referrals sent to the crisis worker through the new referral pathway.

Indicator #14

Percentage of hospital readmissions within 30 days

(Espanola General Hospital)

Last Year		This Year		
10.00	**9**	**8.40**	**--**	**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 the Nurse Navigator in the ED to identify gaps in service for high needs /at risk patients

Process measure

- % of patient with repeat visits in 30 days that have a comprehensive assessment completed. this will be audited monthly

Target for process measure

- 75% of repeat visits within visits within 30 days of discharge will have a comprehensive assessment completed in the ED to identify gaps in service.

Lessons Learned

We have continued with our Nurse Navigator position within the ED.

Our challenge for tracking is that the NN is documenting within a specific assessment in Expanse that other disciplines are utilizing, therefore making it difficult to drill down to their documentation only for tracking.

With the implementation of the new EMR (Expanse) we will be working with informatics to create a referral to the NN which will help with tracking and follow up. This referral stream creation will align with ALC leading practices.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Patient navigator will complete comprehensive discharge planning assessment on all admitted patients to identify barriers to discharge.

Process measure

- # of admissions excluding form 1 patients who have had a comprehensive discharge planning assessment completed

Target for process measure

- 80% of admitted patient will have a documented comprehensive discharge planning assessment

Lessons Learned

Our Patient Navigator assesses each admitted patient. Our internal exclusion criteria would include patients admitted and discharge over the weekend as our PN works weekdays only.

Comment

We will be embedding the creation of the NN referral stream into our ALC leading practice work as per statements in the first change idea successes/challenges.

Access and Flow | Efficient | Optional Indicator

Indicator #13

Percentage of clients with type 2 diabetes mellitus who are up to date with HbA1c (glycated hemoglobin) blood glucose monitoring (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
CB	**CB**	**70.80**	**--**	**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

Leverage digital health tools to inform, educate and engage patients in preventative care and capture baseline data.

Process measure

- to be determined

Target for process measure

- collecting baseline data

Lessons Learned

We noted limitations on staff ability to order additional testing to guide treatment plans for diabetes.

Comment

We will be looking into implementing a medical directive for HbA1C testing.

Access and Flow | Timely | Optional Indicator

Indicator #22

Percentage of screen-eligible people who are up to date with colorectal tests (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
71.50	**75**	**67.20**	**-6.01%**	**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

Leverage digital health tools to inform, educate and engage patients in preventative care

Process measure

- # of emails blasts sent to patients

Target for process measure

- bi-annual preventative care blasts

Lessons Learned

Communication and educational material was made available based on referral guidelines. Patients were also advised/reminded at the time of their appointment about preventative care guidelines.

Comment

We will be removing this indicator from our QIP and monitoring internally.

Indicator #21

Percentage of screen-eligible people who are up to date with cervical screening (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
67.20	**70**	**67.50**	**0.45%**	**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

Leverage digital health tools to inform, educate and engage patients in preventative care

Process measure

- # of email blasts sent to patients

Target for process measure

- bi-annual preventative care blasts

Lessons Learned

Communication and educational material was made available based on referral guidelines. Patients were also advised/reminded at the time of their appointment about preventative care guidelines.

Comment

We will be removing this indicator from our QIP and monitoring internally.

	Last Year		This Year		
Indicator #20	**61.50**	**65**	**55.70**	**-9.43%**	**NA**
Percentage of screen-eligible people who are up to date with breast screening (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Leverage digital health tools to inform, educate and engage patients in preventative care

Process measure

- # of email blasts sent to patients

Target for process measure

- bi-annual preventative care blasts

Lessons Learned

Communication and educational material was made available based on referral guidelines. Patients were also advised/reminded at the time of their appointment about preventative care guidelines.

Comment

We will be removing this indicator from our QIP and monitoring internally.

Access and Flow | Efficient | Custom Indicator

Indicator #16

Percentage of missed/no show Physician and Nurse Practitioner appointments (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
3.80	**3.30**	**3.70**	**--**	**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

Leverage digital health tools to reduce no show/missed appointments

Process measure

- % of no show/missed appointments for Physicians and Nurse Practitioners

Target for process measure

- 3.3% no show / missed appointment rate

Lessons Learned

Ocean reminders were built using patient's preferred method of communication (email and/or text) and confirmation notifications were sent at 1 week, 3 days and 1 day intervals.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Leverage direct communication with patient (letter) reminding of the policy and obligation to show up, or cancel ahead of time or a fee will be incurred

Process measure

- % of no show/missed appointments for Physicians and Nurse Practitioners

Target for process measure

- 3.3% no show / missed appointment rate

Lessons Learned

We have implemented a letter that gets sent to patients who have no -showed reminding them of our cancellation/missed appointment policy.

Comment

We will look to improve patient's ability to change or cancel appointments electronically.

Access and Flow | Timely | Custom Indicator

Indicator #26

The proportion of patients with a progressive, life limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic approach (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
100.00	**100**	**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

Admitted patients with a life limiting illness being discharged home from hospital will have an electronic referral submitted to the Espanola & Area Palliative Care Program.

Process measure

- The number of electronic referrals to the Espanola & Area Palliative Care Program / the number of patients discharged home from hospital with a life limiting illness

Target for process measure

- 70% of patients identified with a life limiting illness who are being discharged home from hospital

Lessons Learned

Referrals sent through Expanse upon discharge from hospital flow to a Vizalert to the FHT Palliative Care Team and they follow up with the patient/POA.

Comment

Internal and community partner working groups are working on pathways for early identification and referral streams.

Equity | Equitable | Optional Indicator

Indicator #25

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
80.95	**85**	**95.83**	**18.38%**	**80**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

increase uptake of required course completion by leadership group

Process measure

- % managers/coordinators who have completed required Surge course will increase each quarter.

Target for process measure

- 50% of managers will have completed the required "Delivering Culturally Safe Patient Care" surge course by March 31, 2026.

Lessons Learned

We are measuring this indicator based on a specific course in our learning management system called: Cultural Competence and Indigenous Cultural Safety - 4 Part series chapter course has test. This course was reviewed and vetted and recommended by our Indigenous Cultural Safety Consultant. This course is currently only being assigned to management and executive level employees, but we will be assigning it to all staff in the future.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Managers will attend an in-person DEI education session annually

Process measure

- % of managers/coordinators who have completed an in-person DEI education session.

Target for process measure

- 50% of managers will have completed an in-person DEI education session by March 31, 2026.

Lessons Learned

We have hosted 1 in person group session for executive, management, board of director and frontline staff. In addition, our Indigenous Cultural Safety Consultant was on site for 3 days and provided 1:1 in-person sessions with the management team with a focus specific to their area of practice.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Develop an DEI plan/framework with an Indigenous focus

Process measure

- Plan will be developed by September 2025

Target for process measure

- 80% of plan/framework development

Lessons Learned

We have created a workplan in conjunction with our Indigenous Cultural Safety Consultant. The plan consists of 30/60/90 day objectives followed by permanently embedding and Indigenous Cultural Safety lead into the management team to continue the implementation of our workplan/framework.

Comment

See above for plans for new position implementation and sustainment/review of workplan.

Equity | Equitable | Optional Indicator

Indicator #24

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Espanola General Hospital)

Last Year		This Year		
80.95	**85**	**95.83**	**18.38%**	**80**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Increase uptake of required course completion by leadership group

Process measure

- % managers/coordinators who have completed required Surge course will increase each quarter.

Target for process measure

- 50% of managers will have completed the required "Delivering Culturally Safe Patient Care" surge course by March 31, 2026.

Lessons Learned

We are measuring this indicator based on a specific course in our learning management system called: Cultural Competence and Indigenous Cultural Safety - 4 Part series chapter course has test. This course was reviewed and vetted and recommended by our Indigenous Cultural Safety Consultant. This course is currently only being assigned to management and executive level employees, but we will be assigning it to all staff in the future.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Managers will attend an in-person DEI education session annually.

Process measure

- % of managers/coordinators who have completed an in-person DEI education session.

Target for process measure

- 50% of managers will have completed an in-person DEI education session by March 31, 2025.

Lessons Learned

We have hosted 1 in person group session for executive, management, board of director and frontline staff. In addition, our Indigenous Cultural Safety Consultant was on site for 3 days and provided 1:1 in-person sessions with the management team with a focus specific to their area of practice.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Develop an DEI plan/framework with an Indigenous focus

Process measure

- Plan will be developed by September 2025

Target for process measure

- 80% of plan/framework development

Lessons Learned

We have created a workplan in conjunction with our Indigenous Cultural Safety Consultant. The plan consists of 30/60/90 day objectives followed by permanently embedding and Indigenous Cultural Safety lead into the management team to continue the implementation of our workplan/framework.

Comment

See above for plans for new position implementation and sustainment/review of workplan.

Equity | Equitable | Optional Indicator

Indicator #23

Percentage of staff (executive-level, management, or all) who have completed relevant equity, diversity, inclusion, and anti-racism education (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))

Last Year		This Year		
80.95	**85**	**95.83**	**18.38%**	**80**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Increase the uptake of required coarse completion by leadership team

Process measure

- % managers/coordinators who have completed required Surge course will increase each quarter

Target for process measure

- 50% of managers have completed course

Lessons Learned

We are measuring this indicator based on a specific course in our learning management system called: Cultural Competence and Indigenous Cultural Safety - 4 Part series chapter course has test. This course was reviewed and vetted and recommended by our Indigenous Cultural Safety Consultant. This course is currently only being assigned to management and executive level employees, but we will be assigning it to all staff in the future.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Managers will attend an in-person DEI education session annually

Process measure

- % of Managers that have completed and in person DEI education session

Target for process measure

- 50% of Managers that have completed and in person DEI education session by March 2026

Lessons Learned

We have hosted 1 in person group session for executive, management, board of director and frontline staff. In addition, our Indigenous Cultural Safety Consultant was on site for 3 days and provided 1:1 in-person sessions with the management team with a focus specific to their area of practice.

Change Idea #3 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Develop an DEI plan/framework with an indigenous focus

Process measure

- Plan will be develop by Sept 2025

Target for process measure

- 80% of plan/framework development

Lessons Learned

We have created a workplan in conjunction with our Indigenous Cultural Safety Consultant. The plan consists of 30/60/90 day objectives followed by permanently embedding and Indigenous Cultural Safety lead into the management team to continue the implementation of our workplan/framework.

Comment

See above for plans for new position implementation and sustainment/review of workplan.

Experience | Patient-centred | Optional Indicator

Indicator #18

Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))

Last Year		This Year		
75.00	**85**	**83.33**	**11.11%**	**85**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Surveys will be administered using paper copy and the NHCASHPS show card annually to all cognitively able residents in November 2025 threw to January 31, 2026

Process measure

- % of resident/POA/SDM that indicated a 4 or 5 start rating

Target for process measure

- 85% of surveys completed will have positive responses by January 31st

Lessons Learned

All cognitively able residents completed the survey via iPad. Cognitively able is determined by CPS scores and assessment of ability at time of survey by DOC. Paper options were also made available and showcards were laminated sheets presented at time of survey.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Surveys will be administered by electronic PDF or paper copy annually in November 2025 and due by January 31, 2025

Process measure

- % of resident/POA/SDM that indicated a 4 or 5 start rating

Target for process measure

- 85% of surveys returned will have a positive response by January 31, 2026

Lessons Learned

Our survey is in Microsoft forms and is printable in the same format. We still distributed paper copies and received 4 paper copies out of 42 total.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Embed matching showcard visual into the survey form.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We embedded the showcards into the Microsoft form.

Comment

We will continue to distribute surveys annually in November and end collection January 31st.

Please note that our survey for this indicator uses a 1-5 star scale. In order to convert our data to the scale being used, we multiplied the number of stars by 2 so that the number would correlate to the 10 point scale. We surveyed 61 residents/POAs and 42 responded. 21 of them gave 5/5 stars. None gave 1/5, 6 gave 3/5 and 14 gave 4/5. We have included 4 and 5 stars into the % calculation and will continue this practice moving forward. 35/42 surveys reflected 4s and 5s, therefore our performance is 83.3%.

Indicator #19

Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))

Last Year		This Year		
87.50	**85**	**71.43**	**-18.37%**	**85**
Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Surveys will be administered using paper copy annually to all resident that cognitively able to participate in the survey.

Process measure

- % of residents that indicate "yes" in response to the question

Target for process measure

- 85% of residents will respond yes to the question

Lessons Learned

All cognitively able residents completed the survey via iPad. Cognitively able is determined by CPS scores and assessment of ability at time of survey by DOC. Paper options were also made available and showcards were laminated sheets presented at time of survey.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Surveys will be administered by electronic PDF or paper copy annually in November 2025 and due January 31, 2025

Process measure

- % of POAs/SDM that indicated "yes"

Target for process measure

- 85% of surveys returned will have a positive Reponses by January 31, 2026

Lessons Learned

Our survey is in Microsoft forms and is printable in the same format. We still distributed paper copies and received 4 paper copies out of 42 total.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Embed matching showcard visual into the survey form.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We embedded the showcards into the Microsoft form.

Comment

We utilized a 1-5 scale for this question this year. Upon data collection we realized we had accidentally changed this question from Yes/No to a 1-5 scale. To correlate the data: 4 and 5 scores we determined to correlate to always and 1,2,3 scores were assumed to mean never. We will be changing the survey back to Yes or No moving forward as it previously was. A total of 42 surveys were collected out of a potential 61.

Experience | Patient-centred | Custom Indicator

Indicator #11

Patients with a progressive, life limiting illness, that are identified to benefit from palliative care, who subsequently have their palliative care needs assessed using a comprehensive and holistic approach in LTC (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))

Last Year		This Year		
100.00	**100**	**72.40**	**--**	**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

Early identification Palliative Care tool will be implemented

Process measure

- % of admissions who have had the early identification tool used

Target for process measure

- 100% of residents will be assessed using the tool

Lessons Learned

This tool has been implemented and is utilized at admission. Our challenge has been to have family members attend the goals of care meetings where this assessment occurs within a 6 week period (threshold). We will be looking at ways to improve attendance with offering other meeting options.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

a palliative care resource/education package will be implemented and distributed to all family members

Process measure

- % of family members that receive the palliative package/education

Target for process measure

- 100% of family will receive the palliative package and education

Lessons Learned

We collaborated with our primary care (FHT) palliative care team to create this package and it has been distributed to family. We will continue to adjust the package in collaboration with the FHT palliative care team.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Advance Care planning conversations with MD will occur within 6 weeks of admission

Process measure

- % of new admissions who have had ACP discussions with 6 weeks of admission

Target for process measure

- 100% of admissions have ACP discussions

Lessons Learned

Our challenge has been to have family members attend the goals of care meetings where this assessment occurs within a 6 week period (threshold). We will be looking at ways to improve attendance/processes.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

An end of life care survey will be developed and administered after each resident death

Process measure

- % of completed surveys

Target for process measure

- 80% of families will have post death survey completed

Lessons Learned

Our social worker has built our survey and calls each family to complete after their loved one has passed. This survey was tailored to LTC using the FHT palliative care team survey.

Change Idea #5 ☐ Implemented ☐ Not Implemented ☑ In Progress

Ongoing palliative care education for registered staff. Develop and implement palliative care education for personal Support workers

Process measure

- % completion of an annual staff education plan

Target for process measure

- 85% of staff will complete annual education

Lessons Learned

RPNs have completed "All-In Palliative Care: Team Approach to LTC course by Centers for Learning Research and Innovation". We will be looking to continue to educate new RPNs with the same course and possibly introduce Pallium. PSWs have not yet completed training- we will be looking at courses that will best suit this cohort.

Change Idea #6 ☐ Implemented ☐ Not Implemented ☑ In Progress

Engage our Social Worker in grief counselling/support courses to support staff, family and residents.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We will be looking at opportunities for this education.

Change Idea #7 ☐ Implemented ☐ Not Implemented ☑ In Progress

Engage our Social Worker in grief counselling/support courses to support staff, family and residents.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We will be looking at opportunities for this education.

Comment

We will be looking to align our palliative care program with the upcoming RNAO clinical pathways.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #9	**94.00**	**95**	**93.50**	**-0.53%**	**100**
Do patients/clients feel comfortable and welcome at their primary care office? (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Continue to collect the survey leveraging digital health tools.

Process measure

- # of patient survey blasts completed

Target for process measure

- bi-annual patient survey blasts

Lessons Learned

As of March 24th, 2520/2695 green smiley responses were collected on our Happy or Not (HON) survey podium at the FHT entrance. We are currently collecting both light and dark green smileys and will continue doing this moving forward.

The survey is not limited to FHT patients, rather accessible to all clients accessing the FHT regardless of modality. Eg- patients accessing the pharmacy or outpatient addictions medicine clinic.

Comment

We will continue to survey utilizing the HON tool. We will look at isolating the podium to the patient care areas of the FHT.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #5 % patients that feel they received adequate information about their health and their care at discharge (Acute Care). (Espanola General Hospital)	**93.00** Performance (2025/26)	**90** Target (2025/26)	**96.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

Survey completion will occur at the bedside prior to discharge by the primary nurse or the PN will complete a phone survey.

Process measure

- % of patients that are discharged that answered "Yes" to question 8,9,10, 11 of the acute care survey.

Target for process measure

- 90% of patients that are discharged from acute care will feel that they have received enough information on discharge.

Lessons Learned

As of March 23rd we are 95.9%: 278/290. When we were pulling data, we noticed that the N/A responses were contributing to the "No" numbers. We have rectified this by changing the data script to exclude N/As.

Some challenges of obtaining the survey are patient willingness to complete as they are in a rush to leave the hospital. Also, sometimes the iPad we use to complete the survey is not charged. We will continue to remind staff to plug the iPad in after use.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Each discharged patient will receive a copy of their discharge instructions on discharge. Instructions will be reviewed with the patient and the intervention documented in the discharge assessment in Meditech Expanse

Process measure

- % of patients that answered "yes" to the question, "did you receive discharge instructions when you left the hospital?"

Target for process measure

- >90% of patients will answer yes to the question

Lessons Learned

As per question #9 on our discharge survey we have achieved a 97.4% rate as of March 23rd. 74/76 respondents felt they received discharge instructions.

Comment

We will continue to utilize our existing survey in Surge to capture data and monitor this indicator.

	Last Year		This Year		
Indicator #6 % patients that feel they received adequate information about their health and their care at discharge (ED). (Espanola General Hospital)	**75.00** Performance (2025/26)	**80** Target (2025/26)	**87.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

Utilize the Happy or Not station survey to track if patients feel they have received enough information about discharge.

Process measure

- % of respondents who selected a green face on the Happy or Not station.

Target for process measure

- 80% of respondents will have selected a green face on the survey station.

Lessons Learned

As of March 23rd, we are performing at 87% 1363/1563 for this change idea. We feel our podium is in a good location to capture data. We are utilizing both dark and green happy faces towards the data.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Utilize the Ed satisfaction survey to track if patients are receiving discharge instructions when they leave the ED

Process measure

- % of patients that answered "yes" to the question, "did you receive discharge instructions when you left the hospital?"

Target for process measure

- >80% of patients will answer yes to received discharge instructions

Lessons Learned

We are not utilizing our survey question #7 to obtain this data. We have seen a poor uptake in survey completion within the ED, despite availability of survey QR codes in each exam room and an iPad kiosk. Our iPad kiosk is located directly beside our HON tool and we are seeing more utilization of the HON vs. iPad. Therefore, we are only using the HON tool to collect this data.

Comment

We will be changing our data source to HON tool only moving forward and collecting all green happy faces. We will consider potentially implementing a paper survey- but will need to assess how this will impact workload.

Safety | Effective | Custom Indicator

	Last Year		This Year		
Indicator #4 % of repeat visits within 72 hours that have admission on second visit to ED (Espanola General Hospital)	**5.20** Performance (2025/26)	**5** Target (2025/26)	**4.80** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

addition of the NN to the ED to help facilitate community services to ensure appropriate care in community

Process measure

- # of repeat ED visits over the number that have had an assessment by the NN

Target for process measure

- 80% of repeat visits to the ED who qualify for NN will have an NN assessment completed

Lessons Learned

We have continued with our Nurse Navigator position within the ED.

Our challenge for tracking is that the NN is documenting within a specific assessment in Expanse that other disciplines are utilizing, therefore making it difficult to drill down to their documentation only for tracking.

With the implementation of the new EMR (Expanse) we will be working with informatics to create a referral to the NN which will help with tracking and follow up. This referral stream creation will align with ALC leading practices.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Daily Vizalert that indicates repeat visits to the ED with admission on second visit, this will allow for auditing/tracking and the opportunity to identify gaps in care and discharge.

Process measure

- Patients will have a comprehensive assessment completed on admission to identify gaps in care and discharge

Target for process measure

- 80% of patients will receive assessment

Lessons Learned

Our Patient Navigator assesses each admitted patient. Our internal exclusion criteria would include patients admitted and discharge over the weekend as our PN works weekdays only.

Comment

We will be embedding the creation of the NN referral stream into our ALC leading practice work as per statements in the first change idea successes/challenges.

Safety | Safe | Custom Indicator

Indicator #2

% change in WPV incident reporting that meets criteria (Espanola General Hospital)

Last Year		This Year		
8.00	**11**	**11.00**	**--**	**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

Continue with increased staff education, training and awareness of WPV protocols, policies and code response

Process measure

- % of staff who have completed relevant WPV education and training

Target for process measure

- 80% attendance rate for all applicable staff to attend GPA and/or NVCI training as appropriate. 80% completion rate for all staff assigned WPV related courses on Surge (code white, purple, silver, harassment and violence HR, Workplace violence and harassment, etc.

Lessons Learned

We have implemented a new hire orientation day where new staff are given in person training and review of code white/silvers/purple, WPV culture and expectations for reporting. We continue to follow our emergency preparedness calendar and facilitate mock codes. We have developed and implemented quick reference guides. Thresholds for code initiations were identified as a gap and we have shifted our education focus to this.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Continue with increased panic alarm testing, awareness and compliance of use

Process measure

- % of monthly testing and audits completed

Target for process measure

- 10 audits minimum per month

Lessons Learned

Panic alarm audits are being completed by our designated IPAC champion.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Continue to work on a standardized process/workflow for WPV incident follow-up and/or debriefing practices as required

Process measure

- % of WPV incidents that had same-day follow-up

Target for process measure

- 95% of WPV incidents will have same-day follow-up

Lessons Learned

This change idea is still in progress. We will be shifting our focus this coming year to standardizing a process for follow up and debriefs of WPV incidents in hopes to branch this approach out to other incidents down the road.

Comment

We will be focusing on our timelines for debriefs of WPV incidents within a specific timeframe (to be determined). We will be re-vamping our incident report forms to pull data directly into dashboards for tracking. We will look at fortifying and standardizing our current debrief package. We will also be looking at debrief education opportunities for managers, coordinators and designates.

Safety | Safe | Optional Indicator

	Last Year		This Year		
Indicator #15	**12.74**	**10**	**16.77**	**-31.63%**	**15**
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

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

Assess each resident for fall risk with in 24 hours of admission, quarterly, annually and when a change in health status has been identified

Process measure

- % of residents assessed for fall risk

Target for process measure

- 100% of residents will be assessed

Lessons Learned

These assessments continue to be completed via scheduled Inter-RAI assessment. We will be hiring a Resident Care Coordinator and these assessments will be part of their portfolio.

Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Discuss and implement fall precautions at time of admission to prevent injury for those residents that have been identified high risk for falls during the pre-admission assessment of needs

Process measure

- % of residents admitted that received proactive fall interventions upon admission

Target for process measure

- 100% will have interventions

Lessons Learned

MORSE fall scale is utilized to assign fall risk at admission and guides implementation of fall prevention measures. We switched from an old assessment tool to MORSE in ~ June.

Change Idea #3 ☑ Implemented ☐ Not Implemented ☐ In Progress

Education for all staff on developing resident specific interventions to prevent falls appropriate use of alarms/restraints and Personal Assistive devices(PASD)

Process measure

- % of staff who have attended the fall training in services

Target for process measure

- 100% of staff will be trained

Lessons Learned

Staff education is ongoing and assessments continue to be resident focused.

Change Idea #4 ☑ Implemented ☐ Not Implemented ☐ In Progress

Implement fall huddles on unit after each resident falls

Process measure

- % of fall huddles initiated on the unit after a fall event

Target for process measure

- 100% of fall will have a debrief

Lessons Learned

All staff immediately involved in care the the fall occurs will attend the post fall huddle.

Comment

We will be adjusting our approach to falls based on the RNAO best practices and clinical pathways, focusing on staff education and monitoring compliance metrics on post fall huddles.

Safety | Safe | Custom Indicator

Indicator #1

% change in WPV incident reporting that meets criteria (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))

Last Year		This Year		
10.00	**13**	**24.00**	**--**	**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

Continue with increased staff education, training and awareness of WPV protocols, policies and code response

Process measure

- % of staff who have completed relevant WPV education and training

Target for process measure

- 80% attendance rate for all applicable staff to attend GPA and/or NVCI training as appropriate. 80% completion rate for all staff assigned WPV related courses on Surge (code white, purple, silver, harassment and violence HR, Workplace violence and harassment, etc.

Lessons Learned

We have implemented a new hire orientation day where new staff are given in person training and review of code white/silvers/purple, WPV culture and expectations for reporting. We continue to follow our emergency preparedness calendar and facilitate mock codes. We have developed and implemented quick reference guides. Thresholds for code initiations were identified as a gap and we have shifted our education focus to this.

Change Idea #2 ☑ **Implemented** ☐ **Not Implemented** ☐ **In Progress**

Continue with increased panic alarm testing, awareness and compliance of use

Process measure

- % of monthly testing and audits completed

Target for process measure

- 10 audits minimum per month

Lessons Learned

Panic alarm audits are being completed by our designated IPAC champion.

Change Idea #3 ☐ **Implemented** ☐ **Not Implemented** ☑ **In Progress**

Continue to work on a standardized process/workflow for WPV incident follow-up and/or debriefing practices as required

Process measure

- % of WPV incidents that had same-day follow-up

Target for process measure

- 95% of WPV incidents will have same-day follow-up

Lessons Learned

This change idea is still in progress. We will be shifting our focus this coming year to standardizing a process for follow up and debriefs of WPV incidents in hopes to branch this approach out to other incidents down the road.

Comment

We will be focusing on our timelines for debriefs of WPV incidents within a specific timeframe (to be determined). We will be re-vamping our incident report forms to pull data directly into dashboards for tracking. We will look at fortifying and standardizing our current debrief package. We will also be looking at debrief education opportunities for managers, coordinators and designates.

Safety | Safe | Optional Indicator

Indicator #10

OLIS: Percentage of clinicians within the primary care practice utilizing this provincial digital solution (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))

Last Year		This Year		
85.00	100	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

Formal onboarding and orientation plan for new clinicians to include education, training on OLIS solution.

Process measure

- % of providers utilizing OLIS

Target for process measure

- 100% of FHT providers will have onboarding and orientation to include OLIS access and utilization

Lessons Learned

We did not implement this indicator.

Comment

We did not implement this indicator and will not be adding it moving forward.

Safety | Safe | Custom Indicator

Indicator #3	Last Year Performance (2025/26)	Last Year Target (2025/26)	This Year Performance (2026/27)	This Year Percentage Improvement (2026/27)	This Year Target (2026/27)
% change in WPV incident reporting that meets criteria (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	4.00	5	9.00	--	NA

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

Continue with increased staff education, training and awareness of WPV protocols, policies and code response

Process measure

- % of staff who have completed relevant WPV education and training

Target for process measure

- 80% attendance rate for all applicable staff to attend GPA and/or NVCI training as appropriate. 80% completion rate for all staff assigned WPV related courses on Surge (code white, purple, silver, harassment and violence HR, Workplace violence and harassment, etc.

Lessons Learned

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Change Idea #2 ☑ Implemented ☐ Not Implemented ☐ In Progress

Continue with increased panic alarm testing, awareness and compliance of use

Process measure

- % of monthly testing and audits completed

Target for process measure

- 10 audits minimum per month

Lessons Learned

Panic alarm audits are being completed by our designated IPAC champion.

Change Idea #3 ☐ Implemented ☐ Not Implemented ☑ In Progress

Continue to work on a standardized process/workflow for WPV incident follow-up and/or debriefing practices as required

Process measure

- % of WPV incidents that had same-day follow-up

Target for process measure

- 95% of WPV incidents will have same-day follow-up

Lessons Learned

This change idea is still in progress. We will be shifting our focus this coming year to standardizing a process for follow up and debriefs of WPV incidents in hopes to branch this approach out to other incidents down the road.

Comment

We will be focusing on our timelines for debriefs of WPV incidents within a specific timeframe (to be determined). We will be re-vamping our incident report forms to pull data directly into dashboards for tracking. We will look at fortifying and standardizing our current debrief package. We will also be looking at debrief education opportunities for managers, coordinators and designates.

Quality Improvement Plan (QIP)

Narrative for Health Care Organizations in Ontario

March 31, 2026

espanola
regional hospital and health centre
hôpital régional et centre de santé
d'espanola

Ontario Health

OVERVIEW

Espanola Regional Hospital and Health Centre (ERHHC) is deeply committed to delivering high-quality, patient-centered care that is safe, timely, and equitable. Over the past year, we have focused on strengthening care delivery through collaboration, evidence-informed practices, and a culture of continuous improvement. By listening closely to the voices of patients, families, and staff, we have identified critical opportunities to enhance outcomes and improve the overall care experience.

One of our proudest achievements has been the advancement of interdisciplinary teamwork across all sectors of care. Through targeted quality initiatives, we have improved communication, streamlined care transitions, and reduced variability in clinical practices. These efforts have contributed to measurable improvements in patient safety, staff engagement, and service efficiency. We have also invested in data-driven decision-making to ensure our improvement efforts are guided by meaningful performance metrics and aligned with system priorities.

At the same time, we recognize that quality improvement is an ongoing journey. Ongoing challenges related to access, workload pressures, and evolving patient needs require us to remain adaptable and innovative. Our QIP represents a strategic roadmap to address these challenges by focusing on priority areas where improvement will have the greatest impact. Through this QIP, we aim to build on our successes, close performance gaps, and sustain improvements over time.
Guided by our mission and values, we remain committed to fostering a learning environment that supports excellence in care. Our QIP activities will help ensure we continue to deliver

compassionate, high-quality care while responding effectively to the changing needs of our community.

ACCESS AND FLOW

ERHHC continues advancing improvement work aligned with ALC leading practices to strengthen access and patient flow, ensuring individuals receive the right care in the right place at the right time. A key focus is supporting seniors and patients with complex needs to remain safely in the community, reducing unnecessary hospitalizations and prolonged inpatient stays. ERHHC now uses the Patient Flow Navigator assessment tool in Meditech Expanse to identify patients at risk for ALC early in their emergency visit. Proactive discharge planning begins at admission and is supported by strong interdisciplinary collaboration. ERHHC also works closely with Ontario Health at Home, community support services, and other partners to ensure timely referrals, coordinated transitions, and appropriate supports prior to discharge. To reduce avoidable emergency department visits, we collaborates with local primary care providers and community services to improve timely follow-up, chronic disease management, and access to community-based supports such as community paramedicine and Ontario Health at Home.

The Espanola Nursing Home (ENH) supports residents with complex needs in a home-like environment. Our 26/27 QIP focuses on equity, resident and family experience, innovation, palliative care integration, and system alignment. Preventive care, early identification of health issues, and comprehensive staff training have improved resident outcomes. In partnership with the RNAO, several best-practice clinical pathways have been implemented, with plans to expand palliative, continence, and skin and wound pathways. An onsite dental program now provides routine exams and treatment to improve oral health.

The Espanola & Area Family Health Team (E&A FHT) is improving primary care access and flow through online booking and technology that reduces administrative burden. Our new clinic for unattached patients enhances equitable access, continuity, interdisciplinary care, and alternatives to ED use-supporting Ontario's goal of connecting every person to a health team by 2029.

EQUITY AND INDIGENOUS HEALTH

We continue to advance health equity and strengthen outcomes for Indigenous and equity deserving communities through intentional, sustained action. This year, we enhanced our commitment to Indigenous health by hiring an Indigenous Cultural Safety (ICS) Consultant to complete a comprehensive review of organizational practices. This included assessing policies, procedures, staff education, and service delivery approaches to ensure alignment with ICS principles and the needs of Indigenous peoples and the Indigenous communities that surround us.

Our consultant's findings and recommendations will guide both immediate improvements and long term system change. Building on this foundational work, we will be recruiting a permanent management level role dedicated to leading Indigenous cultural safety and equity initiatives moving forward, ensuring this work remains anchored in our leadership structure. As part of our consultant's review, a culturally safe learning module within our Learning Management System (LMS) was identified as the most appropriate training to assign to all staff. We will be implementing this organization wide training requirement in the upcoming year,

ensuring that all employees build a consistent foundation of understanding and awareness.

These initiatives complement our broader efforts to improve access and outcomes for equity deserving populations. Through strengthened partnerships, enhanced learning, and a commitment to culturally relevant care, we continue to address systemic barriers and promote meaningful, community informed solutions. Collectively, these actions demonstrate our dedication to advancing equitable, culturally safe care across all levels of the organization.

PATIENT/CLIENT/RESIDENT EXPERIENCE

Our health campus uses patient, family, and caregiver experience feedback as a key driver of ongoing quality improvement. Experience surveys are embedded across care settings to provide timely and accessible opportunities for individuals to share feedback about their care. Patient satisfaction surveys are regularly reviewed by leadership and the QIP committee, and trends identified through this data help guide improvement priorities and action planning. When concerns or gaps emerge, targeted strategies are developed, implemented, and monitored over time. Survey feedback is also shared with frontline staff to support learning, reinforce strengths, and promote a culture of patient- and family-centered care.

The ENH is committed to creating a positive and enriching resident experience by supporting both physical comfort and emotional well-being. This year, we adopted the RNAO Patient and Family-Centered Care Clinical Pathway, which promotes respectful, compassionate, and individualized care through dignity, information sharing, participation, and collaboration. Residents and families determine their preferred level of involvement in care decisions, leading to improved outcomes, greater satisfaction, and enhanced safety through strengthened communication with the interdisciplinary team. Recognizing the varied cognitive and physical abilities of our residents, we enhanced the annual satisfaction survey using visual tools and an accessible online format that can be completed independently or with staff support, ensuring that all voices are heard.

The Complex and Palliative Primary Care Team (CPPCT) within the E&A FHT also uses family and caregiver satisfaction surveys to assess end-of-life care, identify gaps and barriers, and guide quality improvements in accessibility, preferences, hospice support, and overall experience.

PROVIDER EXPERIENCE

Our organization is committed to continually enhancing recruitment, retention, workplace culture, and staff experience through a multi-faceted approach. We have actively leveraged incentives from the Ministry of Health and LTC Health Human Resources Recruitment and Retention Programs, which provide financial incentives, relocation packages, and educational supports for nurses and personal support workers. These programs help us attract top talent and support their professional growth, ensuring a sustainable workforce for the future.

Staff well-being remains a central focus of our ongoing initiatives. We have introduced “Fire Side Chats” with the CEO, offering employees a relaxed and open forum to connect directly with leadership, share their experiences, and voice ideas or concerns. This initiative fosters transparency and strengthens organizational

trust. In addition, our newly launched wellness program features on-site wellness coaches who deliver personalized support, fitness sessions, and mental health resources, promoting holistic well-being among staff members.

To further empower our workforce, we are revitalizing the Employee Advisory Committee (EAC). The EAC will now play a more active role in shaping workplace policies and practices, ensuring staff voices are heard and valued. Based on feedback gathered from the Employee Engagement survey, we will refine our recognition events, such as Thanks a Latte, to be more accessible for staff working various shifts. We will continue with our events such as Rock the Walk and Living our Values draw that celebrate achievements, milestones, and contributions. Further changes will be guided by employee feedback and recommendations. Together, these initiatives demonstrate our dedication to creating an inclusive, supportive, and engaging workplace environment that prioritizes both recruitment and retention and values every employee's experience.

SAFETY

As a small rural hospital, many provincially defined never events do not apply to our scope of services, as we do not perform specialized or high risk surgical procedures. Although our risk profile is lower than larger centres, we continue to monitor relevant never events and maintain strong, consistent safety practices. Our focus remains proactive risk identification, reliable processes, and a culture of safe, high quality care for our patients and community.

A major organizational priority is the development of a comprehensive, campuswide medication management program. This initiative will standardize medication reconciliation, strengthen protocols for high-risk medications, and provide consistent staff training. We will also revise our campuswide wound care program to standardize assessment, treatment, prevention, and documentation. All components will align with legislative requirements, professional practice standards, and evidence based best practice guidelines.

In parallel, we will undertake a full incident reporting system revamp to improve usability, data quality, and follow up. As part of this work, we will shift emphasis to post incident debriefing. We have identified gaps where missed or inconsistent debriefs limit learning and impede system improvements. To address this, we will enhance our debrief guide to be practical and trauma informed and embed it within a formal incident response framework with clear roles, timelines, and communication pathways. Consistent debriefing will support staff well being, enable root cause analysis, and translate lessons learned into actionable improvements. Together, these initiatives will strengthen patient and staff safety, improve organizational learning, and enhance reliability across our hospital.

PALLIATIVE CARE

ERHHC integrates palliative care early and consistently, beginning at the diagnosis of a life-limiting illness and continuing through end-of-life. Early identification of needs enables timely referral to the palliative care team for symptom management, advance care planning, and psychosocial support, reducing unnecessary transitions and distress. The palliative care team supports patients across all settings, following admitted patients throughout hospitalization and after discharge. The palliative NP has admitting

privileges and can initiate and manage orders to ensure timely symptom control and care planning. Both community and inpatient palliative patients are reviewed weekly, and as needed, through interdisciplinary rounds that support seamless transitions between home and hospital.

The ENH provides holistic, person-centered palliative care that addresses physical, psychosocial, and spiritual needs. Early and ongoing goals-of-care discussions begin at admission to align treatment with individual values and preferences. To enhance end-of-life support, the home adopted the Butterfly Model, a visual symbol that respectfully alerts staff, residents, and visitors when someone is nearing end of life, acknowledging the relationships residents form within the home. Annual satisfaction surveys have been enhanced with visual tools and accessible online formats to ensure all voices are heard.

The E&A FHT integrates continuity and accountability in palliative care through its CPPCT, a primary-care–led program that follows patients across clinic, home, LTC, and acute settings. With an NP licensed for MAID and an RN working to full scope, the team provides early engagement, proactive symptom management, rapid response, and care coordination with ERHHC, ENH, and community partners. ERHHC’s campus model supports this continuum, complemented by monthly grief and bereavement groups. The CPPCT also leads internal and community palliative committees to strengthen pathways and improve system-wide quality.

POPULATION HEALTH MANAGEMENT

The Espanola and Area Community of Care Planning Network (CCPN) is essential for health system planning within the Sudbury/Espanola/Manitoulin/Elliot Lake (SEMEL) Ontario Health Team (OHT), contributing to strategic initiatives that improve system performance. The Network develops, executes, and monitors an annual work plan aligned with local health care needs. The CCPN Leadership Council collaborates to deliver integrated health and support services and is committed to achieving the quintuple aim in line with SEMEL OHT's vision and Ministry of Health expectations. Current priorities include palliative care, implementing ALC Leading Practices, mental health and addictions service integration, and connecting unattached patients.

EMERGENCY DEPARTMENT RETURN VISIT QUALITY PROGRAM (EDRVQP)

In our first year of implementation, the EDRVQP review presented several opportunities to optimize and simplify processes for future cycles. PDCA cycles were employed to refine a methodology that effectively served the team and is expected to continue evolving. The structured approach enables the team to adopt a just culture perspective, focusing on identifying system gaps and implementing interventions to support frontline staff.

Small hospitals face challenges running effective EDRVQPs because they lack sufficient resources, data, and capacity. With fewer patients, it's hard to find meaningful trends from limited sentinel events. ERHHC serves rural and underserved communities, where few primary care providers and specialists make follow-up difficult. Therefore, return visits often highlight gaps in community resources rather than problems with ED care quality.

This year, improvement efforts will concentrate on CTAS and medical directive training for frontline staff. Additionally, Care Transitions to long-term care will be a focus, and at the system level, we are exploring ways to broaden our DI Service delivery by adding a CT scanner.

EXECUTIVE COMPENSATION

Performance Improvement Targets drive accountability for the delivery of quality care and patient care services. Our executive compensation, including the percentage of salary at risk and QIP targets that the executive team is accountable for achieving is linked to performance in the following manner:

Senior Management Team:
Chief Executive Officer: 3% of annual base salary is linked to achieving 100% of target.
Chief Nursing Officer: 1% annual base salary is linked to 100% of target.
Chief Financial Officer: 1% of annual base salary is linked to achieving 100% of target.
Chief Human Resources Officer: 1% of annual base salary is linked to achieving 100% of target.

Targets:
1. Access to Care
Average length of DI referral wait time for urgent all modalities
Target: <7 days. Results: 100%

2. Patient Experience
Percentage of complaints acknowledged to the individual who made a complaint within 5 business days
Target: 80% ERHHC. Results: 100%

3. Safety
Develop Indigenous Cultural Safety Program: Complete Phase 1 of ICSP
Target: 100% ERHHC. Results: 100%

4. Effectiveness
Develop Master Plan for Rural Centre of Excellence: Rural Simulation Program portion completed by March 31st (25% of master plan)
Target: 25% of master plan ERHHC. Results: 25%

Terms:
The four indicators/outcome measures are equally weighted. Achievement of the target would result in 100% payout, partial achievement of targets will result in partial payout, as determined by the Hospital Board of Directors.

CONTACT INFORMATION/DESIGNATED LEAD

Anna Love: VP of Clinical Services and Chief Nursing Officer
Kayla Whitfield: Professional Practice and Quality Manager

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**

Karen Lalonde, Board Chair

Louise Gamelin, Board Quality Committee Chair

Martin Lees, Chief Executive Officer

Anna Love, EDRVQP lead, if applicable

Access and Flow

Measure - Dimension: Efficient

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Rate of ED visits for modified list of ambulatory care–sensitive conditions* per 100 long-term care residents. (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))	P	Rate per 100 residents / LTC home residents	CIHI CCRS, CIHI NACRS / October 1, 2024, to September 30, 2025 (Q3 to the end of the following Q2)	23.08	19.00	We would like to see a 1% decrease per quarter.	

Change Ideas

Change Idea #1 Review LTC to ED transfers weekly for trends to identify gaps and process improvement opportunities.

Methods	Process measures	Target for process measure	Comments
The DOC with collaborate with the Data Analyst to create a Vizalert report that captures all LTC to ED transfers, discharge disposition and flags qualifying ambulatory care-sensitive condition.	% of completed weekly Vizalert reviews.	100% of reviews will be completed weekly.	

Change Idea #2	Improve communication between Registered staff and Physician by using a standardized communication tool, structured clinical assessments and clear documentation.		
Methods	Process measures	Target for process measure	Comments
The DOC will collaborate with registered staff and LTC Physicians to select and/or create a standardized communication tool by end of April 2026. All staff will be educated on the communication tool, structured clinical assessments and clear documentation by end of Q1 and reinforced quarterly.	% of scheduled quarterly reinforcement sessions completed as planned.	100% of quarterly reinforcement sessions completed.	

Change Idea #3	Develop and implement a standardized report/process for shift report/handoff to improve efficiency ensure continuity of care.		
Methods	Process measures	Target for process measure	Comments
The DOC will create and implement a structured process for shift report that focuses on key changes, acute issues and pending tasks using SBAR format by end of Q1.	% creation and implementation of SBAR tool.	100% of the tool will be created and implemented.	

Change Idea #4	Enhance clinical training for all registered staff to recognize early signs of common, serious conditions that often necessitate transfers to ED.		
Methods	Process measures	Target for process measure	Comments
The DOC will collaborate with the Chief Nursing Officer and Professional Practice and Quality Lead to develop evidence-based protocols that enable registered staff to respond appropriately to change in resident condition. Educate staff on early recognition of conditions (eg. sepsis, delirium, dehydration) and strengthen clinical skills to manage in the home by end of Q4.	% of staff that has received education to recognize early signs of common, serious conditions that often result in ED transfers.	100% of staff will receive education.	

Measure - Dimension: Efficient

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Number of new patients/clients/enrolments (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	P	Number / PC patients/clients	EMR/Chart Review / Most recent consecutive 12-month period	CB	100.00	We are hoping to enrol a total of 100 net patients in the next fiscal year. In 2025, we enrolled 164 overall patients (not net), therefore we feel 100 is realistic.	

Change Ideas

Change Idea #1 Develop and implement a process for data collection related to patient enrollment by end of Q1.

Methods	Process measures	Target for process measure	Comments
Working with Informatics and PCAC Team, PC Manager will establish a data collection process for patient enrollment numbers via PS EMR.	Finalized process of data collection and generated report receipt.	100% completion of a finalized process for data collection and report generation.	

Change Idea #2 Enroll 95% of the "pre-January 2026" HealthCare Connect waitlist, by end of fiscal.

Methods	Process measures	Target for process measure	Comments
Using Medical directives and clinical pathways, the FHT will enroll patients with a team-based approach.	% of patients enrolled from "pre-January 2026" HCC waitlist (#/151 patients on list).	95% of the pre-January waitlist will be enrolled.	

Change Idea #3 PCAC to begin new patient intakes/enrollments starting April 1, 2026.

Methods	Process measures	Target for process measure	Comments
PC Manager will review and monitor PS EMR Statistics Report related to # of patient Enrollments quarterly.	# of new patient enrollments per quarter.	Enroll 20% more patients than previous year.	Average enrollments over the last 3 years is 148 newly rostered patients. We will be monitoring change idea #3 overall enrollments, instead of net enrollments.

Change Idea #4 Decrease % of unattached CTAS 5 patients, accessing the ED, by end of fiscal.

Methods	Process measures	Target for process measure	Comments
Increasing patient enrollment and access to PCAC, will allow for previously un-rostered patients to have Same-Day appointment access, rather than accessing ED.	% of all CTAS 5 ED visits from unattached patients.	<20% of CTAS 5 visits to the ED will be from unattached patients.	Looking for an overall decrease in CTAS 5 ED visits from unattached patients in the catchment area.

Measure - Dimension: Efficient

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of missed/no show Physician and NP appointments. (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	C	% / missed/no show visits	EMR/Chart Review / April 1, 2026 to March 31, 2027	3.70	4.00	This is the first year in the last 3 years that we have been below our target.	

Change Ideas

Change Idea #1 Update website content to allow for easier access to online booking by end of Q4.			
Methods	Process measures	Target for process measure	Comments
Update messaging on the current website, which includes a splash page/pop-up to encourage online booking for appointments.	Updated website content.	100% completion of updated website content.	Leverage digital health tools by increasing access and opportunities for online appointment management for patients.

Change Idea #2 Increase patient awareness of fees and penalties associated with missed/no show appointments annually.			
Methods	Process measures	Target for process measure	Comments
Email and offer paper copy of the Patient Handbook with policies for No show/missed appointments (reiterating fees associated, etc.) annually in October.	% of patients who received the handbook.	>85% of patients will receive the handbook.	We are hoping that fees and penalties for missed/no shows is a deterrent and will prompt timely cancellation and notification to the team.

Change Idea #3 Update and advertise QR Code (appointment cards, waiting room, clinic room) for online booking by end of Q4.			
Methods	Process measures	Target for process measure	Comments
Post visual reminders about website online booking and QR codes linked to online booking in waiting room, registration, clinic rooms, nursing programming appointment card, physician appointment card.	QR code updated and posted.	100% completion of QR code update and posting.	Increase access and ability to book, reschedule, cancel online appointments with interdisciplinary team by adding QR codes to appointment cards.

Measure - Dimension: Timely

Indicator #14	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Patient/client perception of timely access to care: percentage of patients/clients who report that the last time they were sick or had a health problem, they got an appointment on the date they wanted (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	P	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	CB	80.00	New survey for this fiscal.	

Change Ideas

Change Idea #1 Create a client Experience Survey to be sent out digitally by end of Q1.

Methods	Process measures	Target for process measure	Comments
The PC Manager will collaborate with Informatics to create a survey in Ocean.	% completion of survey creation.	100% completion of survey.	We will be using Q6 from Primary Care patient experience survey: - “The last time you were sick or were concerned you had a health problem, did you get an appointment on the date you wanted?” – a. Yes – b. No

Change Idea #2 Distribute survey at the beginning of the month quarterly- April, June, October, January and collected until the end of each quarter.

Methods	Process measures	Target for process measure	Comments
Survey distributed digitally each quarter via Ocean to patients who have opted into email communications.	% surveys distributed in target months.	100% survey distribution in target months.	We would hope that 15% of our patients would respond/submit the survey. Feedback from surveys will support and promote accountability and continuous quality improvement.

Change Idea #3 Additional options for access to the survey will be available each quarter.

Methods	Process measures	Target for process measure	Comments
The PC Manager will work with Informatics to create a QR code that links to the Ocean survey. The PC Manager will consult the organization's accessibility lead ensure best placement of QR codes and paper copies in patient-accessible areas.	% completion of linked QR code and QR code/paper copy location selection.	100% completion of linked QR code and QR code/paper copy location selection.	We will seek input from our PFAC prior to implementation.

Measure - Dimension: Timely

Indicator #15	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	3.97	4.00	We will continue to align our target with the provincial target for this indicator. We will review our performance and assess any target adjustments after this year.	

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 Utilization of ED medical directives to expedite testing in the ED.			
Methods	Process measures	Target for process measure	Comments
Chart audits to ensure medical directives are being utilized.	% of eligible low acuity patients that have appropriate medical directives initiated on chart audits.	80% of eligible low acuity patients will have appropriate medical directives initiated on chart audits.	

Change Idea #2 Daily huddles to discuss workflow and capacity.			
Methods	Process measures	Target for process measure	Comments
Continue with daily huddles to ensure clear expectations of providers in the ED, addition of white board with daily expectations.	% of daily huddles occurring in the ED.	90% of daily huddles will occur in the ED.	

Change Idea #3 Low acuity patients are being seen by the appropriate care provider.			
Methods	Process measures	Target for process measure	Comments
Monitor share point for all patients seen by NP.	% of patients seen by the NP that are CTAS 4 and 5.	>85% of CTAS 4 and 5 patients will be seen by the NP.	

Measure - Dimension: Timely

Indicator #16	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	5.50	7.00	We will continue to align our target with the provincial target for this indicator. We will review our performance and assess any target adjustments after this year.	

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 Utilization of ED medical directives to expedite testing in the ED.

Methods	Process measures	Target for process measure	Comments
Chart audits to ensure medical directives are being utilized.	% of eligible high acuity patients have appropriate medical directives initiated on chart audits	80% of eligible high acuity patients have appropriate medical directives initiated on chart audits	

Change Idea #2 Daily huddles to discuss workflow and capacity.			
Methods	Process measures	Target for process measure	Comments
Continue with daily huddles to ensure clear expectations of providers in the ED, addition of white board with daily expectations.	% of daily huddles occurring in the ED.	90% of daily huddles will occur in the ED.	

Change Idea #3 High acuity patients are being seen by the appropriate care provider.			
Methods	Process measures	Target for process measure	Comments
Monitor share point for all patients seen by NP.	% of patient seen by the NP that are CTAS 2 or 3.	<15% of CTAS 2 or 3 patients will be seen by the NP.	

Measure - Dimension: Timely

Indicator #17	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to physician initial assessment	P	Hours / ED patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	2.50	4.00	We will continue to align our target with the provincial target for this indicator. We will review our performance and assess any target adjustments after this year.	

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

Change Ideas

Change Idea #1 Continue to develop the NP role to support access and flow and LOS in the ED.			
Methods	Process measures	Target for process measure	Comments
NP will see CTAS 4 and 5 patients.	% of patients seen by the NP that are CTAS 4 and 5.	>85% of CTAS 4 and 5 patients will be seen by the NP.	

Change Idea #2 Utilization of ED medical directives to increase flow in the ED.			
Methods	Process measures	Target for process measure	Comments
Chart audits to ensure ED medical directives are being utilized.	% eligible high and low acuity patients that have appropriate medical directives initiated.	>80% of eligible high and low acuity patients will have appropriate medical directives initiated.	

Change Idea #3 Implementation of VitalHub- a online platform for patients to see real time data on the ED wait times and number of patients in the ED.			
Methods	Process measures	Target for process measure	Comments
Manager of Emergency Department and Chief Nursing Officer will collaborate with Informatics to create and implement VitalHub.	Uptime of VitalHub.	100% implementation of VitalHub.	

Measure - Dimension: Timely

Indicator #18	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of patients who visited the ED and left without being seen by a physician.	C	% / ED patients	CIHI NACRS / April 1, 2026 to March 31, 2027	4.57	4.00	Improvement work with the NP and daily huddles has lowered the LWBS rate on previous QIP therefore we have lowered the target for 26/27.	

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 Implementation of VitalHub- a online platform for patients to see real time data on the ED wait times and number of patients in the ED by April/May 2026.

Methods	Process measures	Target for process measure	Comments
Manager of Emergency Department and Chief Nursing Officer will collaborate with Informatics to create and implement VitalHub.	Uptime of VitalHub.	100% implementation of VitalHub.	This tool will allow patients to make informed decisions about when to visit the ED and may help distribute patient arrivals more evenly throughout the day. Transparent wait times will hopefully reduce congestion in the ED.

Change Idea #2 Continue to develop NP role and procedure/SOW for fast track in the ED on high volume days.

Methods	Process measures	Target for process measure	Comments
Manager of Emergency Department will work with the NP on developing a care model for fast track in the ED by end of Q4.	PIA times on fast track days.	<3.4h PIA times on fast track days.	

Measure - Dimension: Timely

Indicator #19	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Alternate level of care (ALC) throughput ratio (EFFICIENT)	C	Ratio (No unit) / ALC patients	CIHI DAD / April 1, 2026 to March 31, 2027	1.00	1.00	Achieving an ALC throughput ratio of 1 means that the system is managing to efficiently move patients through the appropriate care levels and that the capacity is appropriately utilized without unnecessary delays.	

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	All patients who meet the criteria for PT referral will have a referral sent on admission.		
Methods	Process measures	Target for process measure	Comments
PT will work with Acute Care Manager and PN to develop criteria for referral to PT on admission. Work to develop medical directive that will allow registered staff to initiate PT referral.	% of admitted patients that qualify for PT are referred.	100% of patients who meet criteria for PT will be referred.	

Change Idea #2	Restructuring of multi disciplinary rounds to ensure proper community partners are at the table when discussing inpatients and transitions in care. Develop a tool to facilitate a more structured approach to rounds. Aligns with ALC leading practice work.		
Methods	Process measures	Target for process measure	Comments
PN, Acute Care Manager and community partners will review current rounds template and work to restructure to ensure a collaborative approach to rounds.	% of patients whose admission includes a Tuesday, will have a rounds template completed, including action items and next steps.	100% of patients that are presented at rounds will have a completed rounds assessment.	

Measure - Dimension: Timely

Indicator #20	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of hospital readmissions within 30 days. (EFFICIENT)	C	% / Discharged patients	CIHI DAD / April 1, 2026 to March 31, 2027	8.40	8.00	We have exceeded our previous target of 9% and have already improved this indicator by 1.6%. We will see if we can achieve 8% in the coming year with the ALC work we will be doing.	

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 Espanola and area FHT programming option pamphlet will be created and added to the admission package for acute care admissions by end of Q4.

Methods	Process measures	Target for process measure	Comments
PN, Acute Care Manager and FHT Manager will work together to develop patient friendly pamphlet to reflect all services that are provided by the FHT and the NP referral program.	% of admissions to acute care that have received a pamphlet on admission and % of referrals made to the un-rostered NP program at the FHT (need referral pathway).	100% of admitted patients receive programming pamphlet. 100% of consenting patients are referred to the NP program.	

Equity

Measure - Dimension: Equitable

Indicator #5	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 (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))	O	% / Staff	Local data collection / Most recent consecutive 12-month period	95.83	80.00	This year we will be monitoring the completion of our selected course by all staff (~290) instead of only management/executive level (~25). We feel that 80% or above is a fair target for our first year.	

Change Ideas

Change Idea #1 Increase uptake of required Cultural Competence course completion by all staff by end of fiscal year.

Methods	Process measures	Target for process measure	Comments
Professional Practice and Quality Manager will monitor Surge reports quarterly for "Cultural Competence and Indigenous Cultural Safety - 4 Part series" course completion and send out quarterly email reminders for completion.	% all staff who have completed required Surge course.	>=80% of staff will complete the required Surge course.	

Change Idea #2 Managers/coordinators and executive level staff will attend an in-person DEI education session by end of fiscal year.			
Methods	Process measures	Target for process measure	Comments
Managers/coordinators and executive level staff will attend an in-person DEI education session embedded into one of the scheduled leadership education days.	% of managers/coordinators and executive level staff who have completed an in-person DEI education session.	>=80% of managers/coordinators and executive level staff will complete an in-person DEI education session.	

Change Idea #3 Recruit and onboard an Indigenous Cultural Safety Lead by end of Q2.			
Methods	Process measures	Target for process measure	Comments
Job description/recruitment strategy will be finalized in consultation with Indigenous Cultural Safety Consultant by Q1. Recruitment and onboarding initiatives completed in Q2.	The successful recruitment and on-boarding of a candidate who has the skills, knowledge and qualifications of this position.	100% completion of recruitment and on-boarding of candidate.	

Change Idea #4 Embed and implement in-person Cultural Safety training during on-boarding and orientation by end of Q1.			
Methods	Process measures	Target for process measure	Comments
The Human Resources Manager or designate will facilitate the delivery of Cultural Competence and Indigenous Cultural Safety - 4 Part series course and review the Organization's plan to address the TRC: Calls to Action during in-person on-boarding/orientation day.	% of onboarded staff will have completed the selected course and received TRC: Calls to Action education.	100% of onboarded staff will complete the selected course and will have received TRC: Calls to Action education.	

Measure - Dimension: Equitable

Indicator #6	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 (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	O	% / Staff	Local data collection / Most recent consecutive 12-month period	95.83	80.00	This year we will be monitoring the completion of our selected course by all staff (~290) instead of only management/executive level (~25). We feel that 80% or above is a fair target for our first year.	

Change Ideas

Change Idea #1 Increase uptake of required Cultural Competence course completion by all staff by end of fiscal year.

Methods	Process measures	Target for process measure	Comments
Professional Practice and Quality Manager will monitor Surge reports quarterly for "Cultural Competence and Indigenous Cultural Safety - 4 Part series" course completion and send out quarterly email reminders for completion.	% all staff who have completed required Surge course.	>=80% of staff will complete the required Surge course.	

Change Idea #2 Managers/coordinators and executive level staff will attend an in-person DEI education session by end of fiscal year.

Methods	Process measures	Target for process measure	Comments
Managers/coordinators and executive level staff will attend an in-person DEI education session embedded into one of the scheduled leadership education days.	% of managers/coordinators and executive level staff who have completed an in-person DEI education session.	>=80% of managers/coordinators and executive level staff will complete an in-person DEI education session.	

Change Idea #3 Recruit and onboard an Indigenous Cultural Safety Lead by end of Q2.			
Methods	Process measures	Target for process measure	Comments
Job description/recruitment strategy will be finalized in consultation with Indigenous Cultural Safety Consultant by Q1. Recruitment and onboarding initiatives completed in Q2.	The successful recruitment and on-boarding of a candidate who has the skills, knowledge and qualifications of this position.	100% completion of recruitment and on-boarding of candidate.	

Change Idea #4 Embed and implement in-person Cultural Safety training during on-boarding and orientation by end of Q1.			
Methods	Process measures	Target for process measure	Comments
The Human Resources Manager or designate will facilitate the delivery of Cultural Competence and Indigenous Cultural Safety - 4 Part series course and review the Organization's plan to address the TRC: Calls to Action during in-person on-boarding/orientation day.	% of onboarded staff will have completed the selected course and received TRC: Calls to Action education.	100% of onboarded staff will complete the selected course and will have received TRC: Calls to Action education.	

Measure - Dimension: Equitable

Indicator #7	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	95.83	80.00	This year we will be monitoring the completion of our selected course by all staff (~290) instead of only management/executive level (~25). We feel that 80% or above is a fair target for our first year.	

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 Increase uptake of required Cultural Competence course completion by all staff by end of fiscal year.

Methods	Process measures	Target for process measure	Comments
Professional Practice and Quality Manager will monitor Surge reports quarterly for "Cultural Competence and Indigenous Cultural Safety - 4 Part series" course completion and send out quarterly email reminders for completion.	% all staff who have completed required Surge course.	>=80% of staff will complete the required Surge course.	

Change Idea #2 Managers/coordinators and executive level staff will attend an in-person DEI education session by end of fiscal year.			
Methods	Process measures	Target for process measure	Comments
Managers/coordinators and executive level staff will attend an in-person DEI education session embedded into one of the scheduled leadership education days.	% of managers/coordinators and executive level staff who have completed an in-person DEI education session.	>=80% of managers/coordinators and executive level staff will complete an in-person DEI education session.	

Change Idea #3 Recruit and onboard an Indigenous Cultural Safety Lead by end of Q2.			
Methods	Process measures	Target for process measure	Comments
Job description/recruitment strategy will be finalized in consultation with Indigenous Cultural Safety Consultant by Q1. Recruitment and onboarding initiatives completed in Q2.	The successful recruitment and on-boarding of a candidate who has the skills, knowledge and qualifications of this position.	100% completion of recruitment and on-boarding of candidate.	

Change Idea #4 Embed and implement in-person Cultural Safety training during on-boarding and orientation by end of Q1.			
Methods	Process measures	Target for process measure	Comments
The Human Resources Manager or designate will facilitate the delivery of Cultural Competence and Indigenous Cultural Safety - 4 Part series course and review the Organization's plan to address the TRC: Calls to Action during in-person on-boarding/orientation day.	% of onboarded staff will have completed the selected course and received TRC: Calls to Action education.	100% of onboarded staff will complete the selected course and will have received TRC: Calls to Action education.	

Experience

Measure - Dimension: Patient-centred

Indicator #8	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents responding positively to: "What number would you use to rate how well the staff listen to you?" (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))	O	% / LTC home residents	In house data, NHCAHPS survey / Most recent consecutive 12-month period	83.33	85.00	We will be keeping our target at 85%. We have not met this target for the last 2 years and recognize there is work to be done. We are getting closer to target- previous year performance was 75%.	

Change Ideas

Change Idea #1 Surveys will be provided via electronic link to POAs/SDMSs and cognitively able residents will be surveyed in house by designated/trained staff. The survey will be available November 1, 2026 to January 31, 2027.

Methods	Process measures	Target for process measure	Comments
The DOC will assess each resident's cognitive ability prior to survey distribution. POAs/SDMs of residents who are not cognitively able will receive the survey form link via email by the ward clerk. Paper copies will also be made available if requested. Resident and Family Councils will be made aware at their monthly meetings that the survey is available. Email reminders for completion will be sent to POAs/SDMs December 1st and January 2nd by the ward clerk.	% of residents/POA/SDM that indicated a 4 or 5 star rating.	85% of surveys will have positive responses.	Total Surveys Initiated: 61 Previously created showcards have been embedded into the survey. 33 surveys were completed by the residents, and 9 were completed by POAs/SDMs.

Measure - Dimension: Patient-centred

Indicator #9	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of residents who responded positively to the statement: "I can express my opinion without fear of consequences". (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))	O	% / LTC home residents	In house data, interRAI survey / Most recent consecutive 12-month period	71.43	85.00	We will be keeping our target at 85%. Last year we exceeded this target at 87% but have dropped significantly this past year.	

Change Ideas

Change Idea #1 Surveys will be provided via electronic link to POAs/SDMSs and cognitively able residents will be surveyed in house by designated/trained staff. The survey will be available November 1, 2026 to January 31, 2027.

Methods	Process measures	Target for process measure	Comments
The DOC will assess each resident's cognitive ability prior to survey distribution. POAs/SDMs of residents who are not cognitively able will receive the survey form link via email by the ward clerk. Paper copies will also be made available if requested. Resident and Family Councils will be made aware at their monthly meetings that the survey is available. Email reminders for completion will be sent to POAs/SDMs December 1st and January 2nd by the ward clerk.	% of resident/POAs/SDMs that indicated "yes"	85% of responses will be "yes"	Total Surveys Initiated: 42 Previously created showcards have been embedded into the survey. This year we had a total of 42 surveys completed and returned out of. 33 surveys were completed by the residents, and 9 were completed by POAs/SDMs.

Change Idea #2 Implement a structured review of the Residents' Bill of Rights at every monthly resident and family council meeting, with intentional focus on Resident Right #29—ensuring residents regularly discuss and practice their right to raise concerns freely and without fear of consequences.

Methods	Process measures	Target for process measure	Comments
The chair of each council will review the Residents' Bill of Rights at every meeting by including a standing agenda item that highlights Resident Right #29 in hopes to facilitate open discussion, document themes and concerns and communicate outcomes.	% of resident and family council meetings that have Residents' Bill of Rights #29 as a standing agenda item.	100% of resident council meetings will have Residents' Bill of Rights #29 discussed.	The surveys are anonymous so we are unable to determine which resident/POAs/SDMs feel that there may be consequences to expressing their opinion. We will address this through Resident/Family council, admission, annual care conferences. Our messaging will include that all feedback and opinions are welcomed. They can bring their feedback/opinions/concerns to any member of the care team and/or directly to the leadership team.

Measure - Dimension: Patient-centred

Indicator #10	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Do patients/clients feel comfortable and welcome at their primary care office? (Espanola Regional Hospital and Health Centre (Espanola & Area FHT))	O	% / PC organization population (surveyed sample)	In-house survey / Most recent consecutive 12-month period	93.50	100.00	We would like to see all patients perceive that they feel comfortable and welcome when accessing.	

Change Ideas

Change Idea #1 Rotate the Happy or Not podium within the FHT biannually, starting April 1, 2026.			
Methods	Process measures	Target for process measure	Comments
PC Manager or designate will ensure movement of the HON podium to the following locations: MD Hub (April 1, 2026-September 30, 2026) Nursing Programming area (October 31, 2026-March 31, 2027).	HON podium rotated according to schedule.	100% completion of HON podium rotation schedule.	Currently our HON too is accessible to cohorts outside of Primary Care patients. We are interested to see how bringing the podium to a patient care area will impact our data.

Change Idea #2 Allow for additional feedback on Happy or Not tool, by offering a "Tell us more" feature by April 1, 2026.			
Methods	Process measures	Target for process measure	Comments
The PC Manager or designate will create and implement a QR code and paper feedback box located with the HON podium.	% completion of QR code and paper feedback box.	100% implementation of QR code and paper feedback box.	Additional feedback will support and promote accountability and continuous quality improvement.

Change Idea #3 Update FHT public-facing material to be both English and French, as well as publicize the interpreting service availability, by end of Q4.			
Methods	Process measures	Target for process measure	Comments
FHT public-facing material will be updated to align with campus-wide strategy for inclusivity and accessibility regarding English/French Language, as well as publicize the interpreting service in all public-facing areas.	% completion of updated material.	100% completion of updated material.	

Change Idea #4 Images/artwork in clinic are inclusive and representative of the population by end of Q1.			
Methods	Process measures	Target for process measure	Comments
Indigenous artwork to be added, as well as waiting room signage indicating: Welcome, Bienvenue, Aanii)-as part of the waiting room update.	% of signs and artwork posted.	100% completion of signs and artwork being posted.	

Measure - Dimension: Patient-centred

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% patients that feel they received adequate information about their health and their care at discharge (ED).	C	% / ED patients	Local data collection / April 1, 2026 to March 31, 2027	87.00	80.00	Our current performance is above target we will continue to monitor this as there is room to improve.	

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 Change data source from Surge survey to the Happy or Not (HON) tool only moving forward.

Methods	Process measures	Target for process measure	Comments
We will look to add a second HON tool to the ED department, strategically placed.	% of patients that respond with the dark or light green happy face	>80% of patients will respond by choosing a dark or light green happy face.	We have always collected HON responses and found the uptake better with this tool compared to our survey.

Change Idea #2 Develop and implement paper survey blitzes by end of Q1.

Methods	Process measures	Target for process measure	Comments
The survey will be created by the Acute Care Manager and Registration staff will pass out paper surveys to ED patients monthly. This will be entered into the HON tool at the end of the month for analysis.	Successful creation and implementation of a paper survey that matches the HON tool question.	100% creation and implementation of a paper survey that matches the HON tool question.	

Measure - Dimension: Patient-centred

Indicator #12	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% patients that feel they received adequate information about their health and their care at discharge (Acute Care).	C	% / All acute patients	Local data collection / April 1, 2026 to March 31, 2027	96.00	90.00	Our current performance is above taregt, we will continue to monitor to ensure it does not fall below the target.	

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 Continue to utilize our existing survey in Surge to capture data and monitor this indicator.

Methods	Process measures	Target for process measure	Comments
Staff will continue to prompt survey completion via iPad or personal device upon discharge.	% of patients who respond "yes" to questions 8,9,10,11 on the acute care survey.	>90% of patients will respond "yes" to questions 8,9,10,11 on the acute care survey.	When pulling our performance data for 24/25 we noted that on of the questions was adding N/A responses to "NO" which was skewing the data. We have changed our script so that these responses no long contribute to the data negatively.

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of repeat visits within 72 hours that have admission on second visit to ED.	C	% / ED patients	CIHI NACRS / April 1, 2026 to March 31, 2027	4.80	5.00	We are below out target of 5. We continue to see struggles in the community with lack of registered staffing in the community.	

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

Change Ideas

Change Idea #1 Streamlining referral to the NN in the ED. Working with IT to create a referral pathway to ensure all patients who meet criteria are referred to the NN.

Methods	Process measures	Target for process measure	Comments
Continue to monitor repeat visits to the ED via Vizalert alerting the NN to follow up if no referral.	% of repeat ED visits for patients over the age of 65 who have had a referral to the NN.	>80% of patients age 65 and over with a repeat ED visit will have a referral to the NN.	

Change Idea #2 Analysis of repeat visits to breakdown return for IV ABX, IV restarts, dressing changes.

Methods	Process measures	Target for process measure	Comments
Collaborate with Data Analyst to develop this dashboard.	% completion of Vizalert.	100% completion of Vizalert.	

Measure - Dimension: Safe

Indicator #13	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of LTC home residents who fell in the 30 days leading up to their assessment (Espanola Regional Hospital and Health Centre (Espanola Nursing Home))	O	% / LTC home residents	CIHI CCRS / July 1 to September 30, 2025 (Q2), as target quarter of rolling 4-quarter average	16.77	15.00	The current performance of 16.77% indicates opportunities for improvement. Establishing a target of 15% is both realistic and achievable while still representing a meaningful reduction in the current rate and alignment with Ontario's performance.	

Change Ideas

Change Idea #1 Assess each resident for fall risk within 24 hours of admission.

Methods	Process measures	Target for process measure	Comments
Utilize Point of Care documentation platform and the RNAO fall clinical pathway to complete and track assessments. The ADOC/RCC will audit to ensure that all residents admitted to the home have had a fall risk assessment completed within 24 hours of admission.	% of resident assessed for fall risk with 24 hours of admission.	85% of residents will have a fall risk assessment completed to determine their fall risk level.	

Change Idea #2	Complete post fall assessments to identify contributing factors and prevent reoccurrence.		
Methods	Process measures	Target for process measure	Comments
The RPN will implement and complete the The RNAO Post Fall Assessment within 30 minutes after a fall. This will be audited/tracked by the DOC/ADOC or designate.	% of falls with a completed post fall assessment within 30 minutes.	85% of residents who fell will have a post fall assessment completed within 30 minutes.	

Change Idea #3	Introduce standardized fall huddles after every fall to promote timely team communication, identify contributing factors, and implement targeted interventions to reduce fall reoccurrence.		
Methods	Process measures	Target for process measure	Comments
The RPN assigned to the resident who fell will initiate the fall huddle within 90 minutes of the fall. All available staff involved in the resident's care will attend. The RPN will lead the huddle using a standardized process/checklist created by the DOC. The RPN will lead the identification and implementation of immediate fall-prevention strategies within scope and escalate concerns or initiate referrals when required.	% of resident falls followed by a standardized fall huddle within 90 minutes.	85% of fall huddles will be completed within 90 minutes.	

Change Idea #4	Establish a multidisciplinary Falls Committee to regularly review fall incidents, identify trends and contributing factors, and develop targeted strategies to reduce fall risk.		
Methods	Process measures	Target for process measure	Comments
The DOC will establish and chair a multidisciplinary Falls Committee, mixed with frontline and leadership, that will meet quarterly to review fall incidents, analyze contributing factors and trends, and develop targeted, evidence-based strategies to reduce fall risk and prevent recurrence, with findings communicated to frontline staff for timely implementation.	Presence of a formally established Falls Committee with defined membership, terms of reference, and scheduled meeting frequency.	100% completion of TOR and meeting schedule.	