2026/27 QIP Work Plans
Improvement Targets and Initiatives

AIM		Measure								Change				
Issue	Quality Dimension	Measure/ Indicator	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators	Planned Improvement Initiatives (Change Ideas)	Methods	Process Measures	Target for Process Measure	Comments
M = Mandatory (all cells must be completed) P = Priority (complete ONLY the comments cell if you are not working on this indicator) O= Optional (do not select if you are not working on this indicator) C = Custom (add any other indicators you are working on)														
Access and Flow	**Timely**	**90th percentile emergency department (ED) wait time to inpatient bed.**	O	Hours / ED patients	CIHI NACRS / ERNI hospitals: December 1st 2022 to November 30th 2023. Non-ERNI hospitals: April 1st 2023 to September 30th 2023 (Q1 and Q2).	**27.5 hours** (average from April 1, 2025 to January 31, 2026) 33.39 hours for peer group average (2023/24)	**30 hours**	Reduce the use of ED as admitted patient holding area. Annual target is set based on incremental improvements.		Improve patient satisfaction by transferring patients from the ED to an inpatient bed resulting in a decreased length of stay.	**1)** Physician Cohorting to Units. **2)** Patient and Family Goals of Care Tools. **3)** Bullet Rounds modification - Addition of Patient Estimated Discharge Date (EDD). **4)** Patient Escalation Pathway for Discharge and Ticket Home. **5)** Improve the 1100 hr discharge time.	Number of admissions in the ED at 0800, 1030, and 1500 hr.	% improvement for time to inpatient bed.	
Equity	**Equitable**	**% of management and staff who have completed relevant equity, diversity, inclusion (EDI) and antiracism education.**	O	% Management and Staff	Local data collection / most recent consecutive 12-month period	Managerial: **98%** General Staff: **23%**	Managerial: **95%** General Staff: **25%**	Internal SP2026 Cultural Safety Training Core Team set reasonable targets for Management and General Staff based on the capacity of the Traditional Wellness Lead and Elders. Target is completion of "Repairing the Sacred Circle" (RSC) as part of comprehensive, regionally specific training.	St. Joseph's Care Group (SJCG) - Scientific Accreditation Committee & SJCG Manager of Indigenous Cultural Safety & Education.	SP2026 has an EDI initiative to implement Cultural Safety and other relevant EDI training within the organization.	**1)** Staff: Traditional Wellness Lead, Interprofessional Educator. **2)** Offer various forms of cultural safety and other relevant EDI training to all staff during orientation and monthly RSC sessions. **3)** Develop a plan with Human Resources to identify other funding sources to support and enable participation of previous frontline staff.	**1)** Ensure staffing is maintained. **2)** Track % of staff (broken down by Management and General Staff) who have completed relevant training.	Progress for process measure will be an increase in each quarter until target is reached.	Executive-level target has been removed as 100% achieved in last QIP.
Experience	**Patient-centred**	**% respondents who responded "completely" to the following question:** Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / survey responses	CIHI CPES-IC most recent	Q1-Q3 **69.2%**	**72%**	Target reflects a continued organizational focus on strengthening discharge communication and ensuring patients feel confident managing their care following hospitalization.	OHA peer benchmarking, however benchmarking uses top 2 box.	**1)** Conduct a baseline survey of patient-facing staff to assess awareness and consistency of standardized discharge education requirements (e.g., PODS "Before Leaving the Hospital, All Patients Should Know" and SMARTT discharge process), and use findings to inform targeted education. **2)** Standardize discharge communication by reinforcing the SMARTT framework, implementing a Discharge Confidence Check within the Patient-Oriented Discharge Summary (PODS), and strengthening post-discharge follow-up supports to improve patient readiness for discharge. **3)** Utilize 2025/26 Post-Discharge Liaison (PDL) and health record data to identify patients at elevated risk for readmission and implement enhanced follow-up interventions to support safe transitions and reduce avoidable readmissions.	**1)** Assess baseline staff awareness: Develop and distribute a survey to patient-facing staff to evaluate awareness and use of standardized discharge practices, including the SMARTT discharge framework, teach-back communication, Patient Resource Folders, Patient-Oriented Discharge Summaries (PODS), Patient-Oriented Education Tools (POETs), and whiteboard utilization for goals of care and expected length of stay. Results will inform targeted education and reduce variation in discharge processes. **2)** Promote person-centered discharge communication: Support staff in tailoring communication using person-centered approaches and health literacy principles to enhance patient comprehension and meet diverse care needs. **3)** Optimize patient-oriented education tools: Leverage existing POETs and PODS to promote consistent, plain-language discharge education. Implement a standardized Discharge Confidence Check within PODS to identify patients who may feel unprepared for discharge and require additional support. **4)** Enhance post-discharge follow-up: Continue post-discharge follow-up calls (pending funding) to reinforce discharge instructions, clarify patient concerns, and identify opportunities to strengthen communication practices. Patients identified as higher risk for readmission through 2025/26 PDL and health record data will be considered for enhanced follow-up interventions, where appropriate and with consent. **5)** Strengthen patient and family education: Increase awareness of the PODS framework — "Before Leaving the Hospital, All Patients Should Know" — to support expectation-setting and improve discharge confidence. Education will be reinforced through multiple channels, including Patient Resource Folders, organizational communication platforms, media displays, website content, and in-room materials. **6)** Enable data-driven local improvement: Share CPES-IC results and themes emerging from follow-up interactions with clinical programs to support unit-level awareness, foster leadership engagement, and guide targeted improvements in discharge communication and transition planning.	**1)** Patient response to Q38 on CPESIC. **2)** % of patients who have received written post discharge instructions (through health records audit and PDL statistics and interventions). **3)** % of PDL intervention (suspect decrease of interventions needed if proper discharge process followed). **4)** Additionally, Q38 has been added to ALL inpatient and ED surveys, allowing for greater sample size and internal measure of metric improvement. **5)** Integrate CPES-IC Question 38 into the PDL follow-up process to support deeper analysis of performance and identify targeted opportunities for improvement.	Increase of patients reporting the received paperwork during PDL contact, increase in health record file audit, decrease in interventions needed by PDL. Increase of staff awareness of SMARTT process.	Planned improvement initiatives dependent on continued funding for specific supportive positions set to expire March 31, 2026. If funding were not continued, it would be expected that workplan would have to be revised to meet HHR.
Safety	**Effective**	**Rate of medication reconciliation (Med Rec) at admission:** Total number of admitted patients for whom a Medication Reconciliation is completed within 48 hrs of admission.	O	% completed Med Rec on Admission within 48 hrs / All admitted patients staying >48 hrs (excluding infants that are born in the Hospital)	Local data collection / Most recent consecutive 12-month period	**2025/26 Q3 Results = 55.85%** with Dec and Jan results trending up to **61%** and **63.6%** respectively	**65%**	Target maintained based on current pharmacy staffing resources. The team will continue progressing toward the established target aligned with a full staffing complement.	None	**1)** Obtain baseline data on all completed Med Recs on admission (regardless of timeframe) to better understand overall completion patterns and identify opportunities to increase completion within 48 hours. **2)** Establish baseline LMS Dual Code completion rates and and track rollout of targeted Med Rec education for outpatient clinics. **3)** Continue prescriber and nursing engagement to strengthen understanding of roles and processes related to Med Rec on admission. **4)** Ensure pharmacy resources are appropriately aligned with current admission volumes and Med Rec workload (current and future processes), in alignment with the Pharmacy Health and Human Resource (HHR) Master Plan. **5)** Leverage the Medication Safety Officer (MSO) to utilize audit findings to inform quality improvement and optimization of the Med Rec process.	**1)** Partner with the Business Intelligence (BI)/Decision Support team to complete data extraction and analysis. Use findings to establish baseline performance, identify gaps, and inform targeted improvement opportunities. **2)** Extract LMS completion data and track outpatient clinic education sessions delivered. **3) a.** Utilize audit data and patient safety reports to inform targeted education for prescribers. **b.** Continue pharmacy engagement in unit-based Quality Huddles to reinforce Med Rec expectations. **4) a.** Analyze admission trends and Med Rec workloads to develop a more robust resource allocation plan for Best Possible Medication History (BPMH). **b.** Identify Med Rec pharmacy resources required to go live with Meditech Expanse to help inform the Pharmacy HHR Master Plan. **5)** The MSO will: **a.** Analyze Med Rec audit data to identify process gaps and inform targeted quality improvement initiatives. **b.** Develop improvement recommendations based on identified trends and variations in practice.	**1)** Baseline overall Med Rec completion rate on admission and proportion completed within 48 hours. **2) a.** Percentage of staff who have completed the LMS Dual Code module (baseline established). **b.** Percentage of outpatient clinics that have received direct Med Rec education. **c.** Report back to Med Rec Steering Committee to develop an ongoing education action plan that incorporates process changes for Meditech Expanse. **3) a.** Number of targeted prescriber engagement sessions conducted. **b.** Number of inpatient units with a Med Rec discussion incorporated into a Quality Huddle. **4) a.** Proportion of proactive BPMH completed before and after changes to resource allocation. **b.** Develop a Med Rec resource plan outlining staffing requirements to support Meditech Expanse and inform the Pharmacy HHR Master Plan. **5)** The MSO does the following: **a.** Completion of Med Rec audit data analysis. **b.** Development of targeted quality improvement recommendations.	**1)** Completion of data extraction and baseline analysis by Q4. **2) a.** Establish LMS baseline completion rate by end of Q2. **b.** Deliver Med Rec education to 50% of outpatient clinics by the end of Q2. **c.** Education action plan to be endorsed by the Med Rec Steering Committee by Q3. **3) a.** Deliver targeted prescriber engagement sessions by Q4. **b.** Complete at least one Med Rec Quality Huddle discussion per applicable inpatient unit by Q4. **4) a.** Report on the proportion of proactive BPMH to Med Rec Committee by Q2. **b.** Report on Med Rec resource plan to the Med Rec Committee by Q2 to obtain their endorsement. **5)** The MSO will: **a.** Present audit findings and quality improvement recommendations to the Med Rec Committee by Q2. **b.** Report back to the Med Rec Committee on the implementation of identified process improvements by Q4.	