Access and Flow | Timely | Custom Indicator

	Last Year		This Year		
Indicator #1 Alternate level of care (ALC) throughput ratio excluding any patients with refugee status that are awaiting an immigration hearing (Hotel Dieu Shaver Health and Rehabilitation Centre)	**1.22** Performance (2025/26)	**1.07** Target (2025/26)	**0.92** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

Weekly ALC Rounds meetings that include Hospital Management, Case Managers, Ontario Health atHome staff/Management that review all cases that may have a challenging discharge back to their pre-hospital living arrangement.

Process measure

- Regularity of the ALC Rounds meetings.

Target for process measure

- Weekly meetings to take place.

Lessons Learned

Weekly reviews of patients assisted with discharges to set up Home First plans and use of Transitional Care Beds when available and appropriate. Other discharge settings such as Heavy Care Retirement Homes were also considered when a patient had financial means to afford.

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

Use of Capacity Management and Careview Boards in the new HIS to help track patients and any barriers to discharge.

Process measure

- Regular review of Careview Board at Patient Flow meetings held Monday to Friday.

Target for process measure

- Review of the board at least 4 times weekly.

Lessons Learned

Challenges with the implementation of the new HIS did not allow for tracking via the Careview Boards.

Comment

Results vary significantly from quarter to quarter, with both Q1 and Q3 throughput rates much higher than the provincial rate.
An Intake checklist is being developed to ensure patients being received are appropriate for the levels of care we provide. This will be completed for all inpatient referrals.

Indicator #2

Meet optimal wait times for internal inpatient to outpatient services based on stroke wait times. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year		
18.00	**25**	**83.00**	**--**	**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

Eliminating initial telephone screening in lieu of in-person screening by outpatient hospital staff that will result in faster access to the services.

Process measure

- Monitor the new process and wait time outcomes quarterly.

Target for process measure

- Impact of monthly reviews on wait times.

Lessons Learned

The increase in number of strokes across the region combined with unanticipated extended leaves for staff that were unable to be fully replaced has resulted in the current number.

Comment

Over the past few years application for additional funding has been submitted but unfortunately not granted. We had excellent results on the Stroke Distinction Accreditation survey completed in late May 2025.This indicator will be retired for the 2026/27 QIP.

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #6 Roll out hospital wide DEI training to all staff. (Hotel Dieu Shaver Health and Rehabilitation Centre)	**8.00** Performance (2025/26)	**60** Target (2025/26)	**76.40** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

Education material provided to management, DEI committee members and Human Resources(HR) staff is being reviewed and updated. All staff including management, DEI committee and HR will receive the updated training.

Process measure

- Number of feedback surveys reviewed.

Target for process measure

- 100 % of training opportunities will include staff feedback survey.

Lessons Learned

The DEI committee discussed successes and challenges with the training that they received and this feedback was used to develop the training for inclusion in the Orientation session for all new staff at the time of onboarding.

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

Ensuring that staff returning from long term leaves (illness, maternity, etc) receive DEI training.

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

With the implementation of the new HIS system, staff that have been on extended leaves are required to have re-fresher training on the use of the HIS and the DEI training will be incorporated in with this session.

Comment

Plans are being developed for training of casual staff.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #5 Percentage of complaints acknowledged to the individual who made a complaint within 3 to 5 business days. (Hotel Dieu Shaver Health and Rehabilitation Centre)	**100.00** Performance (2025/26)	**95** Target (2025/26)	**100.00** Performance (2026/27)	**--** Percentage Improvement (2026/27)	**NA** Target (2026/27)

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

Enhanced publication of the contact information for the Patient Relations Process Delegate.

Process measure

- Completion and maintenance of updated information in all areas noted above.

Target for process measure

- Bi-annual checks done at the time of the regular scheduled update to the Patient and Family Handbook to ensure all information is maintained.

Lessons Learned

The Communications department has been a great support to keep the website updated as well as having refreshed posters within the building, in addition to the scheduled updates to the Patient and Family Handbook.

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

Tracking of all formally documented complaints to include time of receipt to time of initial response.

Process measure

- Results reported quarterly to the Quality Committee of the Board, and various hospital standing committees and the Senior Team.

Target for process measure

- 100% of formal complaints to be tracked and responded to in a timely manner.

Lessons Learned

No change. Current process is effective and efficient for our team.

Comment

No changes to be made. The current process is both effective and efficient for the team.

	Last Year		This Year		
Indicator #4	**99.86**	**95**	**98.39**	**--**	**NA**
Patient experience: Would you recommend inpatient care to your friends and family? (Hotel Dieu Shaver Health and Rehabilitation Centre)	**Performance (2025/26)**	**Target (2025/26)**	**Performance (2026/27)**	**Percentage Improvement (2026/27)**	**Target (2026/27)**

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

Results of patient experience surveys shared with staff on each of the inpatient units.

Process measure

- Results presented include numerical information, graphs/charts as well as additional comments received from patients.

Target for process measure

- 100% of all results are presented back to staff.

Lessons Learned

Staff member responsible for collating the survey information for presentation was off for an extended leave, but we were able to transition the process to another staff member successfully.

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

Continue to increase and replace Patient Advisors to assist with sharing of patient experiences

Process measure

- No process measure entered

Target for process measure

- No target entered

Lessons Learned

We have had three new Patient Advisors join this past year and have some new applicants currently going through the onboarding process.

Comment

No change. Current process is effective and efficient for the team.

Indicator #7

Survey 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? (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year		
98.23	**95**	**99.19**	**--**	**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

Continuation of surveys to be conducted with patient (or family member) three or fewer days before anticipated discharge date.

Process measure

- Monthly tracking of the number of discharges and the number of surveys conducted.

Target for process measure

- 100% of patients with pre-scheduled discharge dates to be surveyed.

Lessons Learned

We reached 80% of completed surveys for a number of the months. During outbreaks (Gastro, Covid, Influenza) the Patient Advisors are directed not to meet with affected patients.

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

Continuous communication between Patient Advisors and Clinical Managers to ensure that any concerns are identified and flagged, and addressed prior to discharge.

Process measure

- All surveys are reviewed for concern(s). The Patient Relations Process Delegate is notified and then contact is made with the Clinical Manager to address the concern.

Target for process measure

- 100% of concerns regarding discharge will be reviewed (and ideally resolved) with patient prior to the discharge.

Lessons Learned

Patient Advisors are diligent in notifying the Clinical Managers and/or Patient Relations Process Delegate to ensure any concerns can be addressed in a timely manner.

Comment

No change. The current process is effective and efficient for the team.

Safety | Safe | Custom Indicator

Indicator #3

Number of workplace violence incidents reported by hospital workers as defined by Occupational Health and Safety Act. (Hotel Dieu Shaver Health and Rehabilitation Centre)

Last Year		This Year		
61.00	**60**	**73.00**	**--**	**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

Update staff orientation packages to emphasize the importance and hospital expectations regarding reporting workplace violence incidents.

Process measure

- Orientation and Training completion rates.

Target for process measure

- Monitor staff training throughout year 2025-26.

Lessons Learned

Ongoing education and training with staff about the importance of reporting workplace violence has been very successful and will continue on a regular basis.

Comment

Since the implementation of the new HIS staff have been challenged with the time it takes to report incidents into the electronic incident reporting system (IRS). Updates to the IRS have been started in order to streamline the process for end users. Once completed the plan is to educate staff and roll out in early spring 2026.