Access and Flow

Measure - Dimension: Timely

Indicator #7	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile ambulance offload time	P	Minutes / Patients	CIHI NACRS / December 1, 2024, to November 30, 2025, in alignment with the Pay for Results program	66.00	35.00	Goal is felt to be realistic given incremental improvement in 2025/26. We would like to have a goal that we may be able to celebrate success of meeting. Ontario Health target was reviewed, however this may not be achievable based on the percent of our patients arriving by ambulance, unless we receive additional offload nurse funding to support.	Leed and Grenville EMS

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 Implement 1-2 cardiac monitored spaces within offload location and update offload criteria to align with cardiac monitoring capabilities in this space.

Methods	Process measures	Target for process measure	Comments
Methods include acquiring the needed equipment, updating our offload criteria to account for cardiac monitoring, and communication with ED team to ensure they understand changes to offload criteria.	* Number of patients admitted to offload location * Number of hours patients cared for in offload	Targets for process measures are to be determined, with consideration to historic trends and comparison to other institutions, where such information is publicly available.	This change idea focuses on one of the barriers to timely offload that we identified in 2025/26.

Measure - Dimension: Timely

Indicator #8	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	8.87	6.50	This would be a stretch goal with 1 year post go live of our regional health record and 1 year of online documentation within ED. This would represent a roughly 15% improvement relative to current (Q3) length of stay for low acuity.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Implement point-of-care urinalysis testing within ED then monitor utilization/impact on ED length of stay

Methods	Process measures	Target for process measure	Comments
Methods include acquisition of the needed equipment, putting in place procedures for use and maintenance of the new equipment with consideration to IQMH standards, and training staff on proper use of the equipment	* ED Length of stay for admitted patients * Referral volumes to our Internal Medicine clinics * Wait times by CTAS level * Patient volumes & time of day * Time from POC test ordered to specimen collection * Time from POC specimen collected to results available * ED * Time from ED lab test ordered to specimen collection (breakdown MLA vs nurse collected) * Time from ED specimen collection to accessioned by lab * Time from ED specimen accessioned by lab to results reported (breakdown by specific test) * % of ED specimens collected by MLA vs nurse (filtered by time of day) * Time from ED specimen collection to accessioned by lab * Time from ED specimen accessioned by lab to results reported (breakdown by specific test) * % of ED specimens collected by MLA vs nurse (filtered by time of day) * Balancing Measure: Unscheduled ED Returns within 72 hours & admitted	This is to be determined. Some of the process measures are to monitor other known contributors to ED length of stay - not all process measures will have targets associated with them.	We will review the turnaround times achieved for our POC urinalysis, with consideration to turnaround for non-POC urinalysis.

Measure - Dimension: Timely

Indicator #9	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	10.40	7.90	This is a stretch goal, with 1 year post go live of our regional health record and 1 year of online documentation within ED. Represents a roughly %15 improvement relative to current (Q3) length of stay for high acuity.	

Is this indicator related to:	
Emergency Department Return Visit Audits	Yes
Executive Compensation	Yes
Pay-for-Results Action Plan	Yes

Change Ideas

Change Idea #1 Implementation of daily cross-program interprofessional huddles, focusing on improving patient movement including regular review of DI/Lab turnaround times among other metrics that are to be determined.

Methods	Process measures	Target for process measure	Comments
This initiative is dependent on the availability of data. The ED will be partnering with other programs to launch this interprofessional initiative aimed at improving patient flow in the ED.	* ED length of stay for admitted patients * Referral volumes to our Internal Medicine clinics * Wait times by CTAS level * Patient volumes & time of day * Time from ED lab test ordered to specimen collection (breakdown MLA vs nurse collected) * Time from ED specimen collection to accessioned by lab * Time from ED specimen accessioned by lab to results reported (breakdown by specific test) * % of ED specimens collected by MLA vs nurse (filtered by time of day) * Time from ED specimen collection to accessioned by lab * Time from ED specimen accessioned by lab to results reported (breakdown by specific test) * % of ED specimens collected by MLA vs nurse (filtered by time of day) * Breakdown of DI referrals by assigned triage/priority level, time of day, ordering department, modality * Time from DI exam complete to radiology report available for ED patient (breakdown by time of day, RTR vs in-house radiology, modality) * Time from entry of order for imaging to DI exam start time (breakdown by time of day, modality) * Balancing Measure: Outpatient wait times for diagnostic imaging	For those process measures that are new in 2026/27, we will first need to establish a baseline before determining appropriate and realistic targets for measures.	We were not able to implement this change idea in 2025/26 due to data quality and availability issues.

Change Idea #2 Utilization of data/chart reviews for root cause analysis of high acuity non-admitted pts with greatest ED length of stay

Methods	Process measures	Target for process measure	Comments
The use of chart reviews and data analysis is intended to identify modifiable contributors to ED length of stay	The organization will ensure that there is a threshold number of chart reviews in order to make a determination of potential contributing factors.	As this is a new change idea the target is achieving the total number of chart reviews to ensure a root cause can be accurately determined.	Information learned from review of data and charts will potentially define possible future change ideas.

Measure - Dimension: Timely

Indicator #10	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	6.60	4.75	We selected a target of 4.75 hrs, which represents a ~20% improvement relative to our current performance (6.0) for this fiscal year to date (average of monthly stats from Apr 2025 - Feb 2026). The target of 4.75 is also our best monthly performance on this metric in the past eight quarters to date (Jan 2024 - Feb 2026), therefore we believe it is realistic and achievable.	

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 Evaluation of the RAZ space recently implemented in ED.

Methods	Process measures	Target for process measure	Comments
PDSA cycles will be utilized for continuous feedback, learning, and enhancement.	* ED Length of stay for admitted patients * Referral volumes to our Internal Medicine clinics * Wait times by CTAS level * Patient volumes & time of day * Time from ED lab test ordered to specimen collection (breakdown MLA vs nurse collected) * Time from ED specimen collection to accessioned by lab * Time from ED specimen accessioned by lab to results reported (breakdown by specific test) * % of ED specimens collected by MLA vs nurse (filtered by time of day) * Time from ED specimen collection to accessioned by lab * Time from ED specimen accessioned by lab to results reported (breakdown by specific test) * % of ED specimens collected by MLA vs nurse (filtered by time of day) * Breakdown of DI referrals by assigned triage/priority level, time of day, ordering department, modality * Time from DI exam complete to radiology report available for ED patient (breakdown by time of day, RTR vs in-house radiology, modality) * Time from entry of order for imaging to DI exam start time (breakdown by time of day, modality)* Balancing Measure: Unscheduled ED returns within 72 hours	This is to be determined. Some of the process measures are to monitor other known contributors to ED length of stay - not all process measures will have targets associated with them.	This change idea will build upon progress with our new RAZ space which was implemented in the 2025/26 fiscal year.

Measure - Dimension: Timely

Indicator #11	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
90th percentile emergency department wait time to inpatient bed	C	Hours / All inpatients	CIHI NACRS / fiscal quarter	24.10	17.00	We are targeting 2 hours better than our best monthly performance on this metric in the past eight quarters to date (Jan 2024 - Feb 2026) as a stretch target. Our current performance for this metric for 2025/26 year to date (average of monthly stats Apr 2025 - Feb 2026) is 24.1 - target for this year represents a ~30% improvement relative to our average for 2025/26 year to date.	

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 Revise applicable workflows and space utilization to expedite patient admissions from the ED to inpatient programs.

Methods	Process measures	Target for process measure	Comments
1. Admission and hallway medicine criteria development. 2. Additional surge space utilization. 3. Staffing model review. 4. High volume high impact diagnoses impact assessment. Utilizing root cause analysis and data analysis to support all initiatives.	* Monthly % of admitted patients who had an ED LOS > 20 hrs, * Avg number of bed moves (during same inpatient encounter), * Record level bed moves data, for line by line analysis to identify barriers to flow, * Balancing Measure: Number of instances (unusual occurrences) where a patient rapidly deteriorates within hours of being brought to inpatient unit	All of our process measures for this change idea are new in 2026/27, therefore we will first need to establish a baseline before determining what appropriate and realistic targets for the process measures.	This is a change idea from 2025/26 that has been carried over to our 2026/27 QIP, as this work will continue into the next fiscal year.

Change Idea #2 Optimize early, proactive discharge planning by continuing to make enhancements to our acute interprofessional rounds.

Methods	Process measures	Target for process measure	Comments
This work builds on a pilot of a consolidated rounds format that occurred in 2025/26 as an aspect of one QIP change idea. In 2026/27, we will build on the success of the pilot. We will continue to monitor the effectiveness of rounds, focusing on aspects such as effectiveness of proactive discharge planning, regular participation from roles essential to discharge planning, and exploring feasibility of a bullet rounds format with consideration to other hospitals' experience.	* Actual LOS vs expected LOS for discharged patients * Balancing Measure: Rate of unplanned readmissions	Targets for process measures are to be determined, with consideration to historic trends and comparison to other institutions, where such information is publicly available.	This change idea is carried over from our 2025/26 QIP.

Equity

Measure - Dimension: Equitable

Indicator #4	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of front-line staff and physicians in the past 12 months who have experienced or witnessed unfair treatment or discrimination at work based on personal characteristics.	C	% / Staff	Local data collection / April 2026 to March 2027	15.80	10.00	Target is based on the current performance from a one-time measurement of this indicator during our previous QIP cycle.	

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 Inclusivity training for team leads and reporting incident pathway development.

Methods	Process measures	Target for process measure	Comments
PDSA cycle, with an emphasis on implementation of inclusivity training sessions provided to team leads. Development of reporting incident pathway and associated front-line staff education to understand and inform on the development and implementation of pathways.	1. Quarterly pulse survey response rate 2. % of RL incident reports acknowledged in X amount of time 3. % resolved with documented follow up	1. 10% 2. 75% 3. 75%	

Experience

Measure - Dimension: Patient-centred

Indicator #5	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Percentage of respondents who responded “completely” to the following question: Did you receive enough information from hospital staff about what to do if you were worried about your condition or treatment after you left the hospital?	O	% / Survey respondents	Local data collection / Most recent consecutive 12-month period	50.51	75.00	Target is maintained as per previous year cycle at 75%.	Kingston Health Sciences Centre, Providence Care Centre, Lennox And Addington County General Hospital, Quinte Health, Perth And Smiths Falls District Hospital

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 BGH will continued to support the further implementation of the patient portal platform in conjunction with our regional partners.

Methods	Process measures	Target for process measure	Comments
Phased implementation, patient facing communication plan, monitoring of adoption rates in conjunction with regional timelines and goals.	% of patients enrolled	Collecting Baseline	Total Surveys Initiated: 99

Measure - Dimension: Patient-centred

Indicator #6	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% of respondents who responded positively (Always, I did not want them to be involved, I did not have family or friends to be involved) to the following question: were your family or friends involved as much as you wanted in decisions about your care and treatment?	C	% / All inpatients	In-house survey / April 1, 2026 - Mar 31, 2027	67.00	75.00	Target is maintained as per previous year cycle at 75%.	Ontario Caregivers Organization

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 Upon successful completion of the ECP pilot on CMM and PC, we will be implementing the ECP program to other in-patient units.

Methods	Process measures	Target for process measure	Comments
Project will be implemented using a phased approach. PDSAs focusing on identifying the ECP, Involving the ECP, and Supporting the ECP. Audits will be completed on a 30/60/90 day calendar. Audits will be completed by Patient & Family Experience Specialist and shared with staff during team huddles.	1. Patient experience scores 2. % of admissions with documented ECP	75% of Patients will identify they had friends and family support their care if they wanted them to by March 31, 2027.	

Safety

Measure - Dimension: Effective

Indicator #1	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% Completion of electronic positive patient identification (PPID) and Positive Accession Identification (PAID)	C	% / All inpatients	Local data collection / April 2026 to March 2027	CB	95.00	Target was selected based on working group recommendations.	

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 Improve completion rate of electronic Positive Patient Identification (PAID) for medication administration and electronic Positive Accession Identification (PAID) for specimen collection using the standardized electronic workflow.

Methods	Process measures	Target for process measure	Comments
Review workflow, develop supporting materials, provide staff education and ongoing monitoring.	1. PAID completion rate 2. PPID Med scanning completion rate (both wristband and med barcode scanned) 3. Staff education completion %	1. 95% 2. 95% 3. 100%	

Measure - Dimension: Effective

Indicator #2	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
% Completion of electronic medication reconciliation at admission and discharge	C	% / All inpatients	Local data collection / April 2026 to March 2027	CB	95.00	Target was selected based on working group recommendations.	

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 Improving adherence to electronic admission and discharge med rec completion (95%)

Methods	Process measures	Target for process measure	Comments
1. Implement standardize electronic admission and discharge med rec workflow, e-BPMH for outpatient 2. Implement Cerner flag for admissions and discharges without completed e-med rec 4. Staff education and engagement	1. Admission/Discharge med rec completion rate 2. Provider review rate 3. BPMH completion rate	1. 95% 2. 95% 3. 95%	

Measure - Dimension: Effective

Indicator #3	Type	Unit / Population	Source / Period	Current Performance	Target	Target Justification	External Collaborators
Inpatient falls resulting in harm: The number of reported falls (mild, moderate, severe and death) resulting in harm in inpatient areas as a proportion of 1000 patient days.	C	Proportion / at-risk cohort	Local data collection / April 2026 to March 2027	2.26	1.37	Target is maintained as per previous year cycle.	

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 Reducing inpatient falls through consistent fall prevention interventions targeted at improving falls documentation and developing standardized falls documentation workflow.

Methods	Process measures	Target for process measure	Comments
1. 'turning on' required documentation in patient chart where falls occurred 2. Identifying proper documentation required throughout falls workflow 3. Implement and utilize plans of care 4. Implement patient safety huddles to review falls when they occur for improvement opportunities	1. Post falls risk assessment completion rate 2. High risk patient identification criteria.	As these are new processes and new process measures this year we will be collecting baseline for these measures.	