

Access and Flow | Timely | Priority Indicator

	Last Year		This Year		
Indicator #2	81.00	30	66.00	18.52%	35
90th percentile ambulance offload time (Brockville General Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Maximize utilization of designated offload nurse to full potential

Process measure

- 1. Number of patients admitted to offload location 2. Number of hours patients cared for in offload 3. % of days designated offload nurse in place 4. Hours of designated offload nurse per month

Target for process measure

- Collect baseline

Lessons Learned

Successes in 2025/26 included a renewed focus on strict use of the offload nurse for their intended purpose and a process for resolution of differing assessments between EMS and ED staff. Challenges included lack of cardiac monitoring within offload location.

Change Idea #2 Implemented Not Implemented In Progress

Review and revise Fit to Sit criteria and maximize utilization

Process measure

- 1. Number of patients admitted to offload location 2. Number of hours patients cared for in offload

Target for process measure

- Collecting baseline

Lessons Learned

Challenges included inability to measure Fit to Sit utilization with available data from our EMR. We are looking at the feasibility of enabling this capability in our EMR in the future.

Comment

We plan to address one of the barriers to timely offload identified this year (lack of cardiac monitoring within offload location) via a new change idea for 2026/27.

Indicator #3	Last Year		This Year		
	90th percentile emergency department wait time to physician initial assessment (Brockville General Hospital)	5.52 Performance (2025/26)	4 Target (2025/26)	6.60 Performance (2026/27)	-19.57% Percentage Improvement (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Explore development of RAZ/Fast Track space purposefully designed to expedite time to physician initial assessment and non-admitted patient length of stay

Process measure

- 90th percentile LOS for non-admitted ED patients

Target for process measure

- Collecting baseline

Lessons Learned

One barrier that was difficult to overcome was periods of high volume and becoming bed blocked when there are no longer available beds. Enablers included recruitment of a physician assistant to support the new workflow.

Change Idea #2 Implemented Not Implemented In Progress

Assess and improve lab and diagnostic imaging turnaround times

Process measure

- 1. Time from ED lab test ordered to specimen collection (breakdown MLA vs nurse collected) 2. Time from ED specimen collection to accessioned by lab 3. Time from ED specimen accessioned by lab to results reported (breakdown by specific test) 4. % of ED specimens collected by MLA vs nurse (filtered by time of day) 5. Breakdown of DI referrals by assigned triage/priority level, time of day, ordering department, modality 6. Time from DI exam complete to radiology report available for ED patient (breakdown by time of day, RTR vs in-house radiology, modality) 7. Time from entry of order for imaging to DI exam start time (breakdown by time of day, modality) 8. Balancing Measure: Unscheduled ED Returns within 72 hours & admitted 9. Balancing Measure: Outpatient wait times for diagnostic imaging

Target for process measure

- Collecting baseline

Lessons Learned

Barriers encountered which lead to an inability to carry out this change idea included repeated data quality issues for routine metrics that were expected to be readily available from our new EMR, lack of training and support for our data analysts on the new system, and data analysts being pulled in multiple different directions to assist with work related to the new EMR.

Comment

We have carried forward both change ideas in a different form in our 2026/27 QIP, as both of these initiatives remain important to access and flow in our ED.

	Last Year		This Year		
Indicator #4	4.49	4	5.16	-14.92%	NA
Daily average number of patients waiting in the emergency department for an inpatient bed at 8 a.m. (Brockville General Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Revise applicable staff and physician workflows to expedite patient admissions from the ED to the accepting inpatient program.

Process measure

- 1. 90th percentile wait for inpatient bed (hrs) 2. Time from entry of internal medicine consult request to time consultant arrived to see patient 3. Time from admission order entered to time transfer of care documented 3. Time from transfer of care documented to patient received on inpatient unit 4. Time from admission order entered to bed assigned in Capacity Management

Target for process measure

- Collecting baseline

Lessons Learned

Successes included engagement with front line staff to obtain their input and feedback on changes that will affect their work. Challenges included the number of dependencies between steps that must be taken before some changes could be implemented - this slowed progress on some elements of the change idea.

Change Idea #2 Implemented Not Implemented In Progress

Revise applicable staff and physician workflows to optimize early proactive discharge planning and prioritize discharge orders, along with associated next steps

Process measure

- 1. Avg number of bed moves (during same inpatient encounter) 2. Breakdown of discharge orders by time of day order inputted and location 3. Time from discharge order entry to time discharged patient physically leaves building (breakdown by time of day) 4. Time patient physically leaves building to completion of EVS discharge clean task (breakdown by time of day) 5. Actual LOS vs expected LOS for discharged patients 6. Balancing Measure: Rate of unplanned readmissions within days of discharge 7. Balancing Measure: Number of instances where a patient decompensates/rapidly deteriorates within hours of being brought to inpatient unit

Target for process measure

- Collecting baseline

Lessons Learned

Successes included identifying how patients and families can help facilitate timely, safe discharges. Challenges included lack of success working in partnership with ODSP to date on challenges with discharge transportation.

Change Idea #3 Implemented Not Implemented In Progress

Expedite greater utilization of outpatient clinics (e.g. Ambulatory Care Unit, internal medicine clinic) to prevent avoidable admissions and facilitate safe patient discharges sooner with appropriate supports.

Process measure

- 1. % of patients admitted with ambulatory sensitive conditions 2. % of admissions with LOS between 1-2 days

Target for process measure

- Collecting baseline

Lessons Learned

successes included that we have identified appropriate utilization of clinics in 2025/26.

Comment

We have opted to change this metric for 2026/27, as our organization decided that a measure of # of patients at one point in time was not conducive to or reflective our quality improvement initiatives for access & flow objectives pertaining to patient movement.

Equity | Equitable | Custom Indicator

	Last Year		This Year		
Indicator #7	CB	CB	15.80	--	NA
Percent 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. (Brockville General Hospital)	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 standardized EDI language to be utilized and approved throughout the organization.

Process measure

- Completion of EDI workplan.

Target for process measure

- By April 30, 2025, standardized EDI language will be ready for utilization.

Lessons Learned

EDI language was developed and approved by various stakeholders groups. Initial challenges surrounding how best to apply the language in various formats. Ongoing support of application through AIDE committee.

Change Idea #2 Implemented Not Implemented In Progress

Implementation of Accessibility, Inclusion, Diversity and Equity (AIDE) Committee to combine EDI and Accessibility.

Process measure

- Collection of meeting minutes

Target for process measure

- The AIDE Committee will be in place with a Approved ToR and workplan by September 1, 2025.

Lessons Learned

The implementation of Accessibility, Inclusion, Diversity and Equity (AIDE) Committee to combine EDI and Accessibility was established prior to the target date of September 1, 2025. Additionally, the ToR and workplan was approved prior to the target date. Initial challenges with developing quorum have been resolved.

Change Idea #3 Implemented Not Implemented In Progress

EDI language will be incorporated in 20 policies across the organization including Human Resources, Emergency Preparedness, Governance, and Patient and Family Experience.

Process measure

- Monitor against baseline indicator.

Target for process measure

- By March 31, 2026, twenty policies will include EDI language.

Lessons Learned

20 policies have been selected for review and will be updated with EDI language as necessary by end of fiscal year. Initial challenges of the project were regarding which policies to include as part of this review.

Experience | Patient-centred | Custom Indicator

	Last Year		This Year		
Indicator #1	CB	75	67.00	--	NA
% 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? (Brockville General Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 **Implemented** **Not Implemented** **In Progress**

Find an appropriate place to document the Essential Care Partner(s) in Electronic Health Record.

Process measure

- Patients who want an essential care partner, have an essential care partner.

Target for process measure

- Ability to measure baseline will be in place.

Lessons Learned

Appropriate place to document in Cerner has been identified and tested. Additional documentation requirements are a challenge.

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

2)Pilot the Essential Care Partner Program in at least one program.

Process measure

- Project milestones and uptake of education within the designated unit.

Target for process measure

- By March 31, 2026, 80% of the staff within the pilot program have completed the Essential Care Partner education.

Lessons Learned

ECP program roll out in one pilot area completed. Monitoring is of lessons learned is ongoing.

Experience | Patient-centred | Optional Indicator

	Last Year		This Year		
Indicator #8	CB	75	50.51	--	75
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? (Brockville General Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Leveraging the successful pilot in Mental Health, spread the use of the Patient and Family Guidebooks across at least 1 more program. the admitting nurse from the first program of inpatient admission will provide each patient with a guidebook.

Process measure

- Number of guidebooks provided based on numbers printed and QR code access.

Target for process measure

- 60% of patients within the piloted program have been provided with a guidebook.

Lessons Learned

Guidebooks have been implemented in all in-patient programs. Initial challenges around process for ordering and circulation. Will adjust the review and implementation process as needed to support patients and families as well as care teams.

Change Idea #2 Implemented Not Implemented In Progress

The new Patient Portal is scheduled to be released in June of 2025. We want to help get as many patients on the portal as possible.

Process measure

- # patients admitted who access the Patient Portal, # of patients who do not wish to access the patient portal.

Target for process measure

- By March 31, 2026, BGH will have helped 1000 patients to access the Patient Portal.

Lessons Learned

This is a regional project that BGH is supporting. Regional has opted to implement this using a phased approach and BGH has identified the stroke recovery unit as our pilot program.

Comment

We are continuing to support the regional implementation of the patient portal which will improve communication with patients directly.

Safety | Effective | Custom Indicator

Indicator #5	Last Year		This Year		
	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)
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. (Brockville General Hospital)	1.40	1.37	1.86	--	NA

Change Idea #1 Implemented Not Implemented In Progress

Conduct chart audits in the electronic health records system to determine staff compliance in completing the Morse Falls Risk Assessment upon admission to hospital as an inpatient.

Process measure

- Number of Morse Falls Risk Assessments being completed upon admission by percentage

Target for process measure

- 95% of inpatients admitted to Hospital will have a Morse Falls Risk Assessment completed upon admission.

Lessons Learned

Audits were conducted using a reporting tool within Cerner. The report provided an at-time completion rate which we have met. When the falls risk assessment was not completed, emails were sent to managers to have their team complete outstanding assessments.

Change Idea #2 Implemented Not Implemented In Progress

Conduct chart audits to determine activation of fall prevention independent plans of care in patients who score high on the Morse Falls Risk Assessment.

Process measure

- The number of system generated interdisciplinary plans of care being accepted and initiated in the electronic health record as it relates to fall precautions.

Target for process measure

- 85% of inpatients admitted to Hospital that are identified as a high risk of falls in accordance with the Morse Falls Risk Assessment will have an interdisciplinary plan of care documented in the electronic medical record.

Lessons Learned

This change idea was identified during Lumeo go-live with the presumption of use of interdisciplinary plans of care. These are not currently in use.

Change Idea #3 Implemented Not Implemented In Progress

When conditions of an inpatient's bed are identified as a mitigation to prevent falls through the interdisciplinary plan of care, conduct an audit to determine staff compliance actively managing both the height of the bed and number of bed rails up in an optimized position for patient safety.

Process measure

- Number of bed audits demonstrating compliance to the interdisciplinary plan of care as it relates to prescribed bed rail positioning and height positioning for the bed.

Target for process measure

- 90% of bed audits will yield compliance to the interdisciplinary plan of care as it relates to prescribed bed rail positioning and height positioning for the bed.

Lessons Learned

This change idea was identified during Lumeo go-live with the presumption of use of interdisciplinary plans of care. These are not currently in use.

Change Idea #4 **Implemented** **Not Implemented** **In Progress**

Comprehensive electronic health records analysis to determine the top 3 contributing factors of inpatient falls in Hospital.

Process measure

- Percentage of falls risk assessment completed; percentage of mitigations initiated; count of mitigations initiated; percentage of bed positioning being in the lowest setting; percentage of confusion assessments completed; percentage of restraint application; percentage of interdisciplinary care plans being activated.

Target for process measure

- 95% of core and common strategies with the Hospital's falls risk policy and protocol will be implemented and documented in the patient's electronic medical record.

Lessons Learned

The primary issue pertaining to assessing inpatient falls was quality of documentation. There is opportunity to improve documentation criteria within Cerner, however making changes to Cerner is a regional and timely process. A multitude of local recommendations were made through a report on the findings.

Safety | Safe | **Custom Indicator**

	Last Year		This Year		
Indicator #9	92.00	95	66.00	--	NA
Percentage of staff compliance with hand hygiene before and after patient/patient environment contact (Brockville General Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Determine feasibility of purchasing and implementation of an artificial intelligence solution to monitor hand hygiene compliance.

Process measure

- 1) Vendor demonstrations 2) Product selection 3) Training and education 4) Number of hand hygiene observations completed by the AI

Target for process measure

- 1) Completed 2) Completed 3) 100% of staff in the respective pilot area 4) 5000/quarter

Lessons Learned

A business case was developed, BGH is pausing on implementation in order to leverage lessons learned from KHSC who is implementing the same solution in one unit.

Change Idea #2 Implemented Not Implemented In Progress

Leadership engagement in hand hygiene compliance monitoring (Develop a standard and consistent process to evaluate performance)

Process measure

- 1) Managers and Directors will be trained on how to complete hand hygiene audits 2) Increased hand hygiene audits across the organization 2) Count of hand hygiene audits completed

Target for process measure

- 1) 100% of managers and directors within the organization will be trained on how to conduct hand hygiene audits 2) Count of hand hygiene audits completed per quarter will increase by 33%

Lessons Learned

The organization was able to nominate local champions within each department but compliance and support for completing hand hygiene audits has fallen below the established standards both in count of audits and performance in hand hygiene for moment 1 and moment 4. BGH is currently reviewing the model by which audits continue going forward.

	Last Year		This Year		
Indicator #6	1.00	1	2.00	--	NA
Number of violent incidents that result in lost time claims (Brockville General Hospital)	Performance (2025/26)	Target (2025/26)	Performance (2026/27)	Percentage Improvement (2026/27)	Target (2026/27)

Change Idea #1 Implemented Not Implemented In Progress

Actively monitor and maintain staff NVCI training in mandatory areas and expand NVCI Lite. And Gentle Persuasive Approach into the Transitional Care Program.

Process measure

- Percentage of mandatory staff that have completed their NVCI training

Target for process measure

- 95% of mandatory staff will have completed the necessary NVCI training respective to their clinical area.

Lessons Learned

Heavily dependent on managers to support and push this training to their staff. This became a challenge due to multiple competing priorities for the management teams.

Staff reported difficulties taking the training – availability of training, time outside of work, inability to have shifts covered to take the training, accuracy of training tracked in LMS

Gentle Persuasive Approach, again heavily influenced by the managers ability to launch with the team and the funding to bring this to each department.

Change Idea #2 Implemented Not Implemented In Progress

Provide staff training on when to call security for assistance and what criteria is required to transition into a Code White

Process measure

- Percentage of security activation and/or Code White

Target for process measure

- There will be a 5% increase in the total number of security activations and/or Code Whites

Lessons Learned

Policy, procedure, and training were updated to reflect best practice and legislation. This was implemented widely but difficult to track completion within LMS as the organization is still attempting to correct the issues with the vendor.

Data was heavily reliant on security documentation which is a manual process to collect.